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Official Publication of the

MEDICAL AND CHIRURGICAL FACULTY OF THE STATE OF MARYLAND

MEMBERSHIP ROSTER AND 1955 TRANSACTIONS, Part I,
(See September issue for completion of Transactions.)

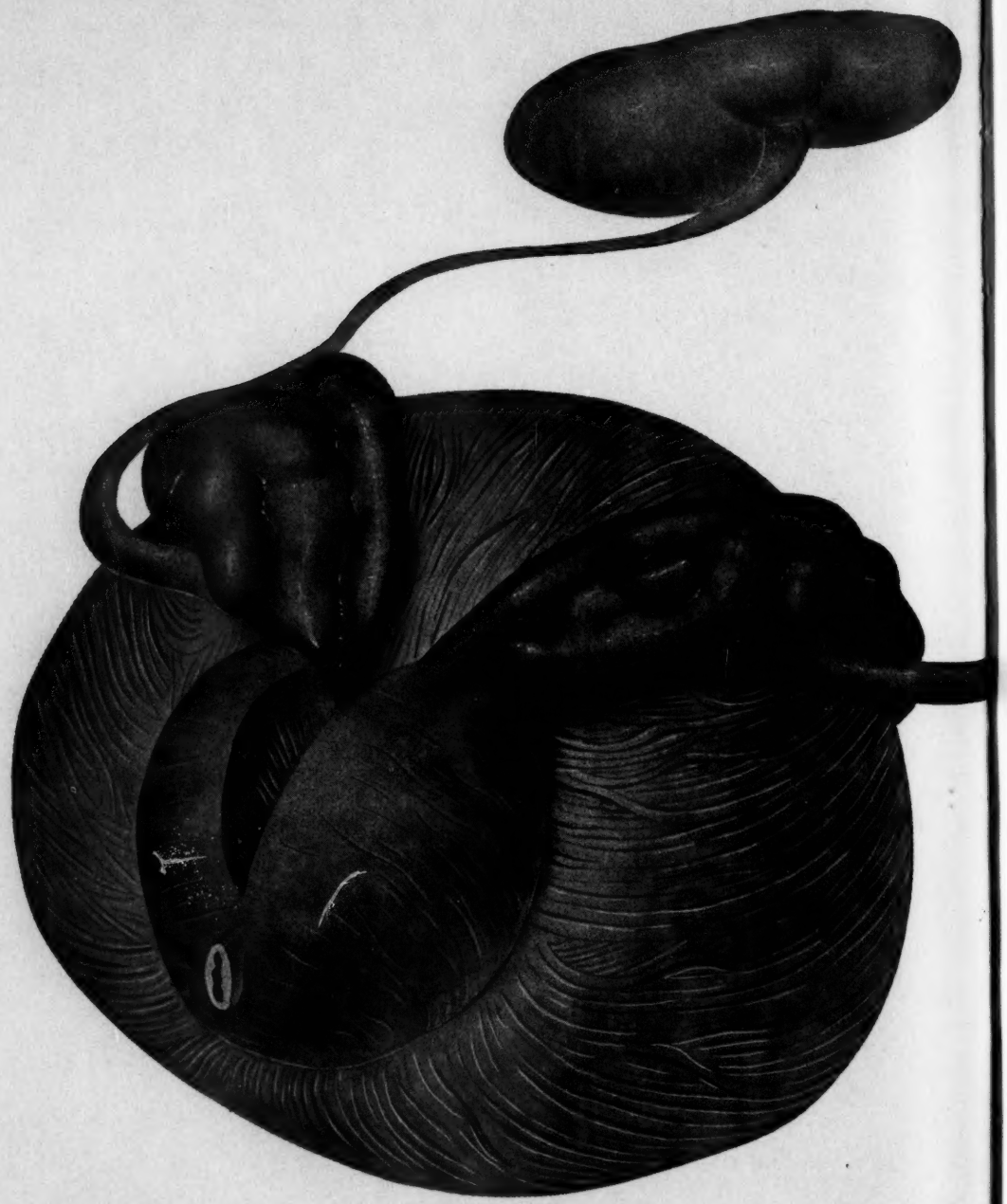
Maryland

STATE MEDICAL JOURNAL

L. 4 NO. 8
gust, 1955

SEMIANNUAL MEETING, FRIDAY, SEPTEMBER 16, 1955
COMMANDER HOTEL, OCEAN CITY, MARYLAND

in severe urinary tract infections.



MARYLAND
STATE MEDICAL JOURNAL
Medical and Chirurgical Faculty of the State of Maryland

1211 CATHEDRAL STREET, BALTIMORE 1, MARYLAND

Official Publication of the Medical and Chirurgical Faculty of the State of Maryland

VOLUME 4 | *August, 1955* | NUMBER 8

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THE MARYLAND STATE MEDICAL JOURNAL

Editorial and Business Office, 1211 Cathedral Street, Baltimore 1, Maryland

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THE MEDICAL AND CHIRURGICAL FACULTY OF THE STATE OF MARYLAND
Secretary's Office, 1211 Cathedral Street, Baltimore, Maryland

1211 Cathedral Street, Baltimore, Maryland
Entered as second-class matter at the Post Office at Baltimore, Md. Acceptance at the special rate authorized

Single Copies, 50¢ *Subscription $3.00 per year*

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SUBSCRIPTIONS: Membership in the Medical and Chirurgical Faculty of the State of Maryland includes subscription to the JOURNAL. Additional copies may be secured from the Editor.

Maryland
STATE MEDICAL JOURNAL
Medical and Chirurgical Faculty of the State of Maryland

VOLUME 4 | *August, 1955* | NUMBER 8

TRANSACTIONS

One Hundred Fifty-Seventh Annual Meeting

MEDICAL AND CHIRURGICAL FACULTY
of the State of Maryland

1211 Cathedral Street, Baltimore, Maryland
April 21, 22, 23, 1955

SCIENTIFIC SESSIONS
Thursday, Friday, and Saturday, April 21, 22, and 23, 1955

BUSINESS SESSIONS
April 21, 22, 23, 1955

ALSO
MEMBERSHIP ROSTER
March 31, 1954–May 31, 1955

FOR COMPLETION OF TRANSACTIONS

See Volume 4, No. 9, September, 1955, Maryland State Medical Journal, for completion of 1955 Transactions.

Scientific Sessions

THE EDUCATIONAL ROLE OF THE MEDICAL AND CHIRURGICAL FACULTY[1]

GEORGE H. YEAGER, M.D.[2]

It is fitting for us as a medical society to survey ourselves and to determine whether or not we are utilizing our great opportunity and challenge to the best possible advantage. In the medical profession, we need more physicians who are conscious of their responsibilities and obligations as members of a great professional group, the integrity and efficiency of which is being tested now as never before.

How we develop our potentialities as a profession, and to what ends we use our influence as a component of society must be a matter of vigilant concern which cannot be left to special individuals and study groups. Like citizenship, the greatest effectiveness results from personal concern and acceptance of responsibility.

Are we—as a medical society—utilizing our great opportunity and challenge to the best possible advantage.

One of the stated purposes of the Medical and Chirurgical Faculty is to elevate the standard of medical education. The Principles of Medical Ethics of the American Medical Association under physicians' responsibilities states, "they recognize instinctively that the need for improvement of medical knowledge and skills is never at an end, and while they strive toward satisfaction of this need, they are zealous in making available to physicians of good character who possess the desire and ability to learn the aggregate of progress in medical education, research and discoveries as they may exist at the time."

Traditionally, and since its founding, the Medical and Chirurgical Faculty has demonstrated an interest in the problem of medical education. An effective and thriving example of this interest is the University of Maryland School of Medicine. The roots of that school are intimately associated with the founding of the Medical and Chirurgical Faculty, and for many years that body was the constituted patrons and visitors of the College.

In addition, the Board of Examiners (of the Faculty) was designated as the major part of the governing body of the College, and the President of the Medical and Chirurgical Faculty as the ex officio Chancellor of the College!

Cordell, in his historical sketch of the University of Maryland stated: "The culmination (of the efforts of the medical profession to form an organized society) was reached in 1799, in the passage by the General Assembly of the State, of the charter of incorporation of the Medical and Chirurgical Faculty of Maryland. Those were wise and far-sighted physicians who conceived and secured the passage, by the highest legislative tribunal of the state, of this admirable law, which at once united all the practitioners in the state into a comprehensive organization, and conferred upon them, in their corporate capacity, absolute control of all professional interests. That this charter has fallen into desuetude and proven inoperative in the course of years is due

[1] Presidential Address, presented at the One Hundred and Fifty-seventh Annual Meeting of the Medical and Chirurgical Faculty of the State of Maryland, on Thursday evening, April 21, 1955, Main Ballroom, Sheraton Belvedere Hotel, Charles and Chase Streets, Baltimore 2, Maryland.

[2] President of the Medical and Chirurgical Faculty of the State of Maryland.

to the apathy and want of spirit of their successors, and illustrates a well-known truth, that not only are good laws necessary, but the men also to see to their excecution."

For purposes of discussion, perhaps it would be best to delineate the term "medical education." Actually there are three major divisions of medical education: (a) Undergraduate medical education leading to the M.D. degree; (b) Graduate medical education as typified by residencies, fellowships, etc. and serving the purpose of preparation for entrance into a speciality, board certification, or an advanced academic degree. These two phases of education are generally conducted by medical schools, hospitals or graduate medical schools.

In 1910, the Flexner report effected an elevation of medical education in the United States to a degree of uniformity nowhere equalled in the world, and therefore as a Medical Society, undergraduate medicine does not represent a field of interest. However, perhaps it would be wise if organized medicine were again to express an interest in the general educational background of young doctors. Much has been sacrificed in recent years toward the development of a technical education. Not every doctor need be a scholar but nevertheless, a broad educational background would assuredly prepare him for a better understanding of his relationship to his environment. As Dr. W. H. Elkins stated in his presidential address to the American Surgical Society: "He should concern himself with the problems of man and society, but he cannot do this if his thinking and awareness do not go beyond the confines of a single field of endeavor."

If undergraduate medical education does not belong within the scope of organized medicine, certainly graduate and postgraduate education should be an area of real activity. Too frequently postgraduate education is being used as a guise for the admission to this country of inferiorly trained foreign graduates. This group, theoretically ineligible for State Board Examination, is subsequently declared eligible after one or two years of postgraduate education.

Unless both the American Medical Association and the State Department develop a much more realistic approach to this problem, the impact on the medical profession will be an inevitable lowering of professional standards.

The phase of postgraduate education that relates to accreditation of residency training should also become a field of broader interest. Many small hospitals which have had extremely effective postgraduate programs are now handicapped by (1) an inability to attract graduates of American medical schools for postgraduate training; (2) the imposition of arbitrary standards that frequently do not reflect the effectiveness of a given program. Standards that are as inelastic as a cook book or a military regulation should not be applied to the diverse problems of the average community hospital in a country so geographically varied as ours. That this has become a matter of concern may be witnessed by a resolution of the Baltimore City Medical Society introduced at this year's session of the House of Delegates:

"WHEREAS, the Council on Medical Education and Hospitals of the American Medical Association through the joint committee on accreditation has served the community well by elevating standards of hospital care, of the practice of medicine and of residency training programs, and

WHEREAS, recently there has been an increasing amount of dissatisfaction by the staffs of hospitals inspected, particularly the smaller ones, since many of the requirements are said to be arbitrary, others impractical and unrealistic, and

BE IT RESOLVED, that this Committee of the B.C.M.S. urges the President of the Medical and Chirurgical Faculty of the State of Maryland to appoint a Committee to study this problem."

The third phase of medical education, that of

postgraduate medical education, consists of those educational activities engaged in by individuals possessing the degree of doctor of medicine which are primarily designed to keep them abreast of their own particular field in medicine. Such activities are intended to both refresh the individual in various aspects of his basic medical education and inform him of the new developments within his field. Such programs are sponsored by a diverse group of institutions, schools and organizations.

Should the State Medical Society play a role in the development of postgraduate medical education? In a survey of the members of the Medical and Chirurgical Faculty conducted by Dr. Edwin Stewart, Jr. (Chairman of the Fact Finding Committee-Postgraduate Education-Medical and Chirurgical Faculty), to study this problem, it was revealed that of 2,484 inquiries sent to the members, 1,025 were returned. Of this latter number, 1,019 favored postgraduate education. This represents approximately 41.02% of the total membership.

The Council on Medical Education and Hospitals of the American Medical Association has collected data on the number of postgraduate courses offered and total physician attendance for the past 16 years. Over two-thirds of the medical educators and other authorities interviewed in the course of the American Medical Association survey expressed the opinion that interest in postgraduate medical education was increasing among physicians, and only a small number felt it to be decreasing. It was concluded in that report that there is a gradually increasing demand for postgraduate courses among physicians who are coming to look upon them as a necessary part of their continuing education.

Buerki and Wilkinson, in a Report of the Commission on Graduate Medical Education in 1940, stated that physicians need to be refreshed in all aspects of medicine every four to five years, and specialists even more frequently. Based on collected data, it is probably safe to recommend that all physicians receive postgraduate training at no greater than three to five year intervals. Many physicians themselves have suggested an equivalent of about 10 days per year. The American Academy of General Practice requires 150 hours every three years of its members, only 50 of which must be of a formal nature, such as in postgraduate courses. This would be the equivalent of about six eight-hour days in three years, or two eight-hour days per year.

To keep up with the need, it will be necessary to expand the services of postgraduate education so that all practicing physicians can be reached. On the organizational local level, the Medical and Chirurgical Faculty must share in this responsibility.

It is a mistake to say that you will continue in the future as you have in the past. The rapid advance of science has made this an impossibility. This Society, if it is going to retain its lustre, must become a more dynamic force in the lives of the individual physician member. It now renders an extremely effective service in a variety of directions, and of a magnitude unfortunately not understood by the general membership.

Perhaps by meeting the need of postgraduate education a better understanding of the comprehensive role this Society plays in the daily lives of its members may also be accomplished!

Medical Arts Building
Baltimore 1, Maryland

THE SURGICAL TREATMENT OF PEPTIC ULCER[1]

DERYL HART, M.D.[2]

DERYL HART, M.D.

It is not only a great honor but a real pleasure to me to play a small part in this most appropriate way of honoring that great surgeon and humanitarian, my former chief, Dr. John M. T. Finney.

Dr. Finney was widely known for his ability to illustrate a point in a discussion by a timely story or anecdote told in the dialect of the Negro race for whom he had a great affection dating back to his childhood and his Negro nurse.

I can illustrate my recent problem in no better way than by imitating this man whom we honor in telling one of my own experiences. In the enthusiasm of youth while resident and in a spirit of undue optimism I was operating under local anesthesia on a poor risk 450 pound Negro man, suffering with a large incarcerated umbilical hernia with almost complete intestinal obstruction. He had been particularly insistent on having a general anesthetic. When the operation was about half completed, the patient became somewhat curious and asked, "Doctor, what is you doing"? My answer was the question, "I am not hurting you, am I?". With this, he poured forth a continuous flood of repetitious pleadings, the essence of which was "Doctor, please put me to sleep, just please put me to sleep, I don't care what you does to me, you can cut my head off, but just please put me to sleep." In an attempt to talk to him, I said "Wait a minute, wait a minute, answer my question, am I hurting you?" To this he gave the immediate reply, "Doctor, indeed I cannot tell you a lie at a time like this; you ain't hurting me a-tall, but I's doing a powerful lot of thinking."

In the words of this old Negro, I have been doing a "powerful lot of thinking" as to what would be most suitable for a Finney lecture. Naturally, the surgical treatment of peptic ulcer came to mind since Dr. Finney had always been greatly interested in this. It is a field in which he pioneered, in which he was one of the "giants" of his time, and to its development he not only gave much of his time and thought, but in 1901 he added the Finney pyloroplasty to the surgical procedures available for its relief (Fig. I). Upon learning that no previous Finney lecture had been on this subject, it seemed to me to be most fitting for this occasion.

It was my privilege to work under Dr. Finney as a student and a resident and to spend many delightful days as a guest in his home. It was also my pleasure to have your own Dr. George Finney as first assistant when I was resident and best man when I was married. While many of you

[1] John M. T. Finney Fund Lecture. Presented at the One Hundred and Fifty-seventh Annual Meeting of the Medical and Chirurgical Faculty of the State of Maryland, on Friday, April 22, 1955, in Osler Hall, 1211 Cathedral Street, Baltimore 1, Maryland.

[2] Professor of Surgery and Chairman, Department of Surgery, Duke University Hospital, Durham, North Carolina.

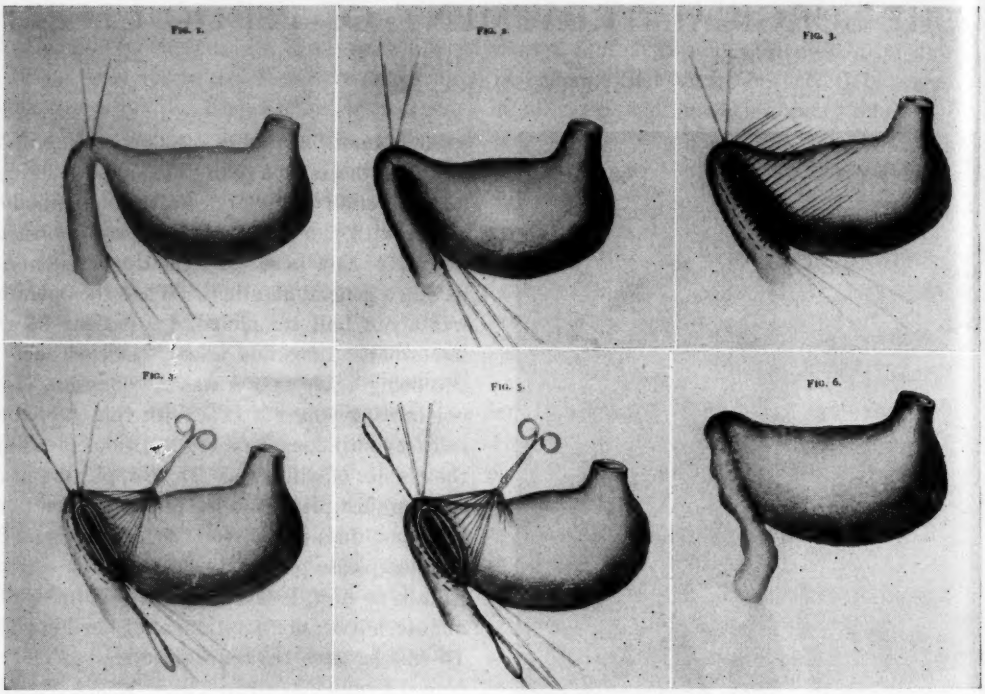


FIGURE I

Illustrations taken from Dr. Finney's original publication of his pyloroplasty operation.

knew the senior Dr. Finney better than I, there are undoubtedly many others who did not have this opportunity. Therefore, I would like to take a few minutes to recite some of my personal experiences to illustrate his great moral and intellectual honesty as well as his thoughtfulness for and interest in others who had not reached his position of eminence.

While resident surgeon at The Johns Hopkins Hospital, I accepted an invitation to spend a vacation with the Finneys in Nova Scotia. I was instructed to be at the railroad station in Baltimore at train time. All travel arrangements had been made and a ticket for which no payment would be accepted was provided. It was stated simply that I was their guest from the time we left Baltimore. A few days later in a canoe accident my wallet containing a return ticket and, for me, a considerable amount of money was lost. A few weeks later, at the time of leaving for Baltimore, Dr. Finney helped me on the train with my bags and stood with me on the open platform until the train was pulling out of Chester. He then hurriedly took an envelope from his pocket, saying, "Mrs. Finney asked me to give this to you," and immediately stepped off the moving train. In the envelope was a return ticket and the approximate amount of money that was lost with a note stating that they did not want my vacation marred by the unpleasantness of my loss.

Each day while in Nova Scotia Dr. Finney's chief interest was what I would prefer to do: sail, picnic, fish for salmon or trout, play golf, sail in the races, etc.

Dr. and Mrs. Finney were at all times helpfully aware of the small income of a doctor in residency training. At this time when only an

occasional member of the house staff owned an automobile, if one had a date to go to the opera with his beloved daughter, Meemie, their chauffeur stayed on to drive them, while, if we were going to a movie, we rode the trolley or surreptitiously called a cab from the hotel across the street. Mrs. Finney would discourage any call from her home with the statement, "take the streetcar, you have no business wasting your money on taxicabs."

My first experience with Dr. Finney's reaction to a catastrophe in his professional life came while, as third year students, our class watched him perform a thyroid operation during which the patient died on the table, suddenly and unexpectedly. He turned to the class and said, "if this had to happen, I am glad that you are here to witness it. You must learn that such things can occur and there is only one way for the surgeon to react. He should do his best at all times and if such a thing happens, he must remember that for the one he loses there are many that he can save. We will proceed with the next operation." The following week he had the autopsy findings presented. The patient died of an air embolus, a condition which has ever since been foremost in my mind during any operation on the neck.

Three years later I performed an autopsy on another patient operated on by Dr. Finney before the class, and was asked to present the findings at his next operative clinic. I showed the organs, demonstrated the cause of death, and turned to leave the room. I was immediately recalled by Dr. Finney with the statement, "I believe there was another finding in this case." I then stated that a stay suture had penetrated the peritoneal cavity and passed through the transverse colon, but without leakage, obstruction or infection and therefore it had nothing to do with the death of the patient. He thanked me, stated that this knowledge would make everyone more careful and therefore might save a life. Only a few of us ever knew that the closure had been made by the resident surgeon. Dr. Finney made no attempt to place the responsibility on another, but he wanted the error in technique and its possible consequences known for the sake of untold patients of the future.

Another evidence of Dr. Finney's absolute professional honesty was the referral of his patients to others who had developed an operation which he considered superior to what he had been doing. This was illustrated by his work on spastic torticollis for the relief of which he had worked for years and had developed an extensive operation for cutting the nerves and muscles in the neck. When Dr. Dandy began treating such patients by cutting these nerves intradurally with much less trauma, Dr. Finney discontinued the neck operation which he had developed and referred to Dr. Dandy all possible patients.

When I was resident surgeon I became interested in a closed method of treating empyema by what was described by me as tidal irrigation. Dr. Finney considered this an improvement in treatment. One day he called and asked if I would come over to The Union Memorial Hospital and set up a tidal drainage apparatus for the treatment of the president of The Johns Hopkins University who had acute empyema. After my arrival, Dr. Finney insisted that I perform the operation as well as set up the irrigation apparatus, stating that with my experience in this I could insert the tube for this special purpose better than he. When the lung expanded too rapidly and resulted in the first walled off abscess in my series, Dr. Finney resisted all efforts the family physician made to get him to take over. Much to my embarrassment and with considerable concern and mental strain, I performed the second operation with Dr. Finney and the family physician looking over my shoulder. Fortunately, the patient following this made a rapid recovery.

After I went to Duke University in 1930, patients of Dr. Finney came to me stating that he had written them that it was not necessary to

make the trip to Baltimore, but to come to me at Duke for treatment.

In 1929 Dr. Finney presented before the American Surgical Association the results of operations performed for peptic ulcer in The Johns Hopkins and Union Memorial Hospitals during the years 1900 through 1925. Knowing Dr. Finney as I did, it was not surprising to me that he made no attempt to separate his personal cases from those of the less experienced and changing residents. Furthermore, the operative mortality was based not on the hospital stay, but included any deaths occurring within the next six months from any cause that might be considered as a complication of the operation. The mortality from posterior gastroenterostomy was given as 16% and that from the Finney pyloroplasty as 5.8%. It was not emphasized that the reported series began in the early days of gastric surgery and that all peptic ulcers, even marginal ulcers and perforated ulcers were included.

This frankness of one of the outstanding surgeons of the Country in evaluating a method of treatment resulted in the demand from the floor for a symposium on the surgical treatment of peptic ulcer at the next meeting of the American Surgical Association held in Philadelphia in 1930. For the latter meeting Dr. Finney was asked to bring his results up to date. He reported that for the five year period from 1925 to 1930 the operative mortality at the Hopkins and The Union Memorial Hospitals had been 2.4% for posterior gastroenterostomy and 0% for pyloroplasty. After breaking down the report covering the years from 1900 to 1925, the operative mortality for non-perforated ulcers had been 8.2%, for perforated ulcers 23.6% and for marginal ulcers 20%. These figures we must remember extended back over 30 years of gastric surgery and covered deaths from any complication for six months postoperatively. Of those surviving the operations 84.6% had been improved.

In addition to Dr. Finney's report, Drs. Horsley, Gatewood, Balfour, Judd, Bloodgood, Fordyce B. St. John, Hartwell and Felter, John Gibbons, Douglas, Bevan, Nystrom, W. J. Mayo and Eugene Poole discussed the problem or reported series of cases from one or more hospitals in Richmond, Chicago, Rochester, Minn., Baltimore, New York and Philadelphia. The reported series of cases other than Dr. Finney's went back to around 1915 or 1920. In these different series operative mortality ranged from 1.8% to 15.1% for posterior gastroenterostomy, while 59 to 88% of those surviving showed great improvement, 6 to 18% additional showed some improvement, 11 to 22% showed no improvement and 4% of the patients in one series were reported as developing a recurrent ulcer.

At this time resections were the exception rather than the rule in the surgical treatment of peptic ulcer. Dr. Finney reported that there had been no death in his series of 15 such operations. There were other references to resection, but at times with a high mortality. In these reports, both in 1929 and 1930, sympathectomy was referred to frequently and there were a number of references to cutting the vagus nerves. These operations were soon dropped. Vagotomy was revived later by Dragstedt who undoubtedly performed a more complete division of these nerves. This operation has more recently been tried by many surgeons.

The operative mortality for gastroenterostomy, which by present standards was high, was predominantly from pulmonary complications, peritonitis, and malfunctioning stomas, the latter being designated as a vicious circle. These were in reality cases of high intestinal obstruction and were at that time recognized as such.

At the close of this symposium, Dr. Balfour gave the following summary:

(1) "It is obvious that no operation used only when other treatments have failed will give perfect results in all cases of such a chronic disease."

(2) "It is a fatal mistake to try to establish one operation for all types of peptic ulcer."

(3) "Best results are being obtained by the surgeon who knows how to select the patient for operation and how to select the operation needed."

(4) "Excellent results frequently follow an indirect operation alone such as a gastroenterostomy."

(5) "Other things being equal, and where the same surgeon is carrying out the different procedures, more patients will die following a partial gastrectomy as a primary operation than will develop recurrent ulcers following a conservative procedure."

(6) "Leaving aside the mortality rates there is very definite conformity of results of gastroenterostomy in chronic duodenal ulcer. These figures (85–90% of definite improvement) presented by various members of the American Surgical Association are convincing evidence of what can be accomplished in chronic duodenal ulcer by indirect operations alone."

During the past 25 years since these statements were made there have been great reductions in the operative mortality particularly in patients having resections.

I would like to list certain general developments which I feel have played a great part in improving the over-all results in the surgery of peptic ulcer.

I. There has been a great increase in the percentage of patients having resections. It has been possible to extend the magnitude of the operation in order to reduce the chance of development of marginal ulcers and still have a lower mortality because of greater ability to control infections; better knowledge of function, nutrition and blood chemistry; and technical improvements in the operative procedures. However, one must remember at all times that it is possible to remove too much stomach and we should not forget that in selected cases good results can still be obtained by more limited and indirect operations.

II. The opportunity to select one of a number of operations which best suits the individual patient. These include:

(a) The gastroenterostomy, either anterior or posterior, or the Finney pyloroplasty which may be used for the obstructive lesion in an old patient who is a poor operative risk, who has a low acidity, and who has a history of an ulcer extending over many years.

(b) Any one of several types of gastric resection and anastomosis with their modifications may be used in the patient who has a high acidity and a history of a very active ulcer.

(c) One of the exclusion operations for duodenal ulcers may be used where removal of the ulcer would be unusually difficult and carry a high risk.

(d) Vagotomy and gastroenterostomy are available for very active ulcers, whose removal will prove to be unduly difficult, as in the duodenum with penetration and extensive reaction or gastric ulcers near the esophageal opening. In these cases a gastroenterostomy alone may give complete relief and I have had very favorable results in two cases where the stomach was resected distal to a gastric ulcer near the esophageal opening.

(e) Vagotomy for the marginal ulcer without obstructive symptoms which does not respond to medical treatment.

(f) In the presence of an early perforation it is usually possible to perform a resection with hopes of cure rather than be content with simple closure of the perforation.

III. More well trained surgeons give the

average patient the advantages of better surgical judgment and technical skill.

IV. The development of blood banks with the ready availability of blood has undoubtedly saved many lives.

(a) The patient's blood can be quickly restored to a relatively normal level before operation, either in the patient suffering from chronic anemia or in the one having had an acute hemorrhage.

(b) Shock during operation can be avoided by adequate blood and fluid replacement.

(c) When postoperative hemorrhage occurs, most patients can be carried over without a second operation if there is adequate blood for replacement. Of course, if the hemorrhage persists either postoperatively or from a bleeding ulcer, it must be controlled by surgical measures.

With the ready availability of blood to combat shock and with our ability to control infection, we can carry out a primary resection in many patients having an acute perforation, can save many of the patients with uncontrolled hemorrhage and can operate with relative safety on many of the patients with gastrojejunocolic fistulas or other marginal ulcers which produce severe symptoms, thus improving results and lowering the mortality.

V. Patients in general are operated on before they reach the extreme degree of starvation formerly seen all too frequently.

VI. Greater knowledge of nutrition; electrolyte, protein and vitamin balance; improvements in the knowledge of, and availability of blood chemistry determinations; with facilities for parenteral administration of the more essential products needed to carry the patients through treatment in a better state of nutrition.

VII. Antibiotics have reduced the mortality by the control of infections in the peritoneal cavity, the incision, the lungs, and the urinary tract.

VIII. The revival of vagotomy, particularly in conjunction with some type of drainage operation.

IX. Improved technical knowledge with virtual absence of the complications of the malfunctioning stoma and leakage at the suture line. The abandonment, to a large extent, of the retrocolic anastomoses has played a part in reducing the number of malfunctioning stomas. Also, with the anastomoses anterior to the colon and therefore more accessible, handling of the malfunctioning stoma or the marginal ulcer with or without a gastrojejunocolic fistula is simplified. We now have a definite and satisfactory plan for the relief of a malfunctioning stoma when such a complication occurs.

X. Improvements in surgery and anesthesia are such that repeated operations do not carry a high operative risk. To me it seems preferable to avoid removal of more than 60–65% of the stomach at the primary operation. A second operation in a very occasional patient who develops a marginal ulcer is a small price to pay in order to leave the majority with a more adequate amount of stomach which enables them to maintain a normal weight and nutrition following resection.

XI. Among our patients there seem to be fewer who have the so-called dumping syndrome.

XII. There is an increasing ability among the medical profession to differentiate the patient who will need surgery from that larger group who can be treated satisfactorily by dietary measures.

XIII. The development of adequate small drainage tubes for the stomach and for small intestinal intubation has affected favorably the entire field of abdominal surgery.

XIV. Greater knowledge of how to handle the non-functioning intestinal tract following anesthesia and operation or in the presence of peritonitis.

XV. A reduction in the percentage of wound disruptions.

Innumerable recent reports in the literature give a relatively low operative mortality. This is under 1% for resections for gastric ulcer and in the range of less than 1–3% for resections for duodenal ulcer. The net result of this improvement has been that on our service at Duke Hospital we have added to the classical indications for operation, namely, obstruction, uncontrolled or recurring hemorrhage, perforation into the free peritoneal cavity, and posterior penetration with intractable pain, the broad indication that we will operate on any patient who is otherwise a good risk, if it is found that he cannot continue with his chosen occupation and lead a reasonably satisfactory life.

I will make no attempt to survey the voluminous literature that has accumulated on the treatment of peptic ulcer, much of which you have read and all of which is available. I will now recount the development of surgery in this field at Duke Hospital. The surgery of peptic ulcer as we perform it today is built on the great developments of the original pioneers, influenced by the writings and demonstrations of contemporaries, and, with certain changes, based on our own experiences. I will give the greater part of my remaining time to the latter since we have never reported on these procedures considered by us to have been of great value in improving our results.

I. The first great lesson learned by us from experience was that the malfunctioning stoma, whether following a gastroenterostomy or a resection could be relieved in most cases by performing an entero-enterostomy between the jejunal loops proximal and distal to the anastomosis. The next step in our development of a better solution for the problem of the malfunctioning stoma was the use of a plastic operation on the jejunum at the site of the anastomosis. This might be called an enteroplasty (Fig. II) and is similar to a Finney pyloroplasty (Fig. I). This consists of an anastomosis between the proximal and distal loops of the jejunum, including the anastomotic area and permits the stomach to empty directly into the efferent loop which should leave this new anastomotic area without kinking. I have never seen this procedure fail to give relief of the obstruction at the site of either a simple gastroenterostomy or the anastomosis

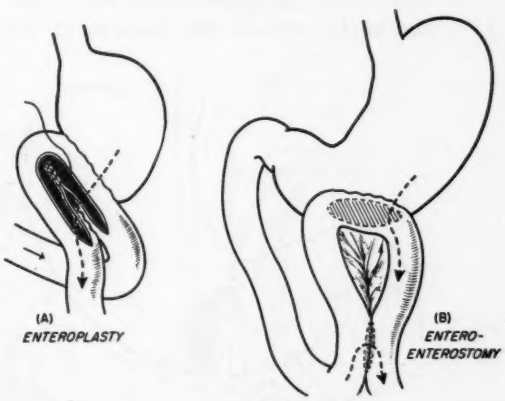


FIGURE II

A. Enteroplasty, similar in principle to the Finney pyloroplasty, but performed on the jejunum. The proximal and distal loops of jejunum following a Polya type resection and anastomosis are thrown together. This permits the stomach contents to pass across the new anastomotic area and enter the distal loop of jejunum. The kink in the jejunum at the lesser curvature has been eliminated and the obstruction at that point relieved.

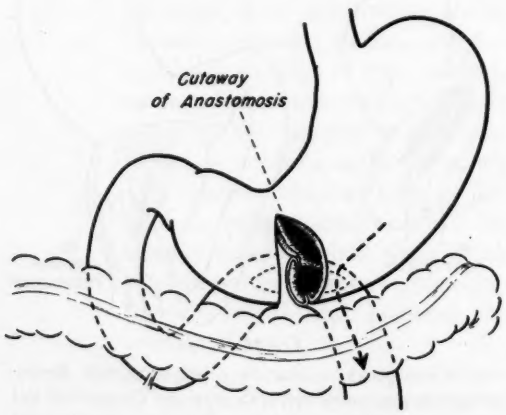
B. Enteroenterostomy associated with an anterior gastroenterostomy. It is evident that an enteroplasty similar to "A" can be performed following a gastroenterostomy and in my opinion is preferable to an enteroenterostomy for the relief of a malfunctioning stoma.

secondary to a resection. If, for any reason, the enteroplasty cannot be performed, an enteroenterostomy between the proximal and distal loops will usually relieve the obstruction.

In one patient of mine, in whom the proximal loop became obstructed following a resection for carcinoma, the jejunum perforated from necrosis due to over distention interfering with the blood supply. This condition was corrected by utilizing the perforation as the opening in the proximal loop for an enteroenterostomy between the proximal and distal loops. This accomplished two objectives; first, it closed the perforation and, second, it drained the obstructed loop. The patient made a satisfactory recovery. It might be argued that both the enteroenterostomy and the enteroplasty, by diminishing the alkalinity at the stomal site might increase the chances of the development of a jejunal ulcer. However, the immediate urgency of relieving the malfunctioning stoma takes precedence over the possibility of the more remote development of a marginal ulcer in only an occasional patient.

II. Our greatest improvement in functional results came with a better understanding of the cause of these obstructions at the anastomotic site. I will list these in the order in which they were impressed upon us and following which we attempted to correct them.

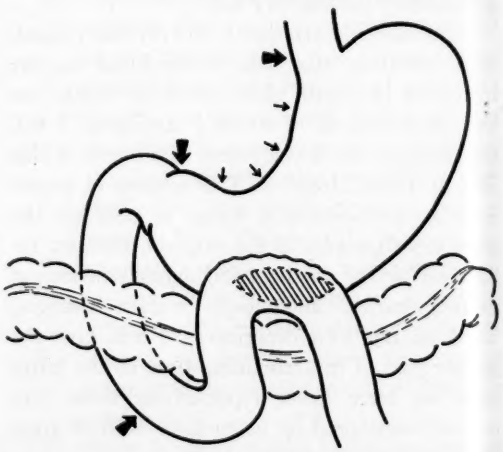
(a) In the earlier days we used too short a proximal loop of jejunum (Fig. III). This error resulted from the great emphasis which had been placed on the so-called "no loop posterior gastroenterostomy" which was thought to be essential in avoiding the development of a malfunctioning stoma. Such a short loop resulted in tension on the segment of jejunum extending from Treitz ligament to the anastomosis and was not



TOO SHORT PROXIMAL LOOP
(Posterior Anastomosis)

FIGURE III

Posterior gastroenterostomy with the proximal loop of jejunum too short. With the two fixed points at Treitz ligament and the attachment of the stomach to the transverse mesocolon, obstruction may be caused either by tension on the jejunum or by angulation of the intestine at one or more of the points of fixation.



FIXED POINTS

FIGURE IV

Anterior gastroenterostomy showing the points of fixation at Treitz ligament and along the lesser curvature of the stomach.

manifest while the stomach was drawn down for the operation. However, after traction on the stomach had been released and the anastomotic site had retracted upward and to the left, tension was made on the proximal jejunal loop. This not only impaired function by tension, or angulation, or both, but made more difficult any subsequent operation for relief of the obstruction.

(b) Too many fixed points were present particularly in the retrocolic anastomoses (Fig. IV). These were at Treitz ligament, the lesser curvature of the stomach in resections, and the opening in the transverse mesocolon in all retrocolic anastomoses (Fig. V). These points of fixation increase the possibilities of kinking or tension which may result in partial or complete obstruction. In order to minimize these fixed point effects we adopted the antecolic anastomoses both for the simple gastroenterostomy and for the anastomoses following resection. We also used a proximal loop of jejunum sufficiently long to avoid tension after the stomach had assumed its normal postoperative position and after the intestine had regained its normal tone. This loop was kept as short as compatible with the above stated objectives in order to diminish the chances of a marginal ulcer.

(c) Our next improvement in results was obtained by avoiding kinking of the

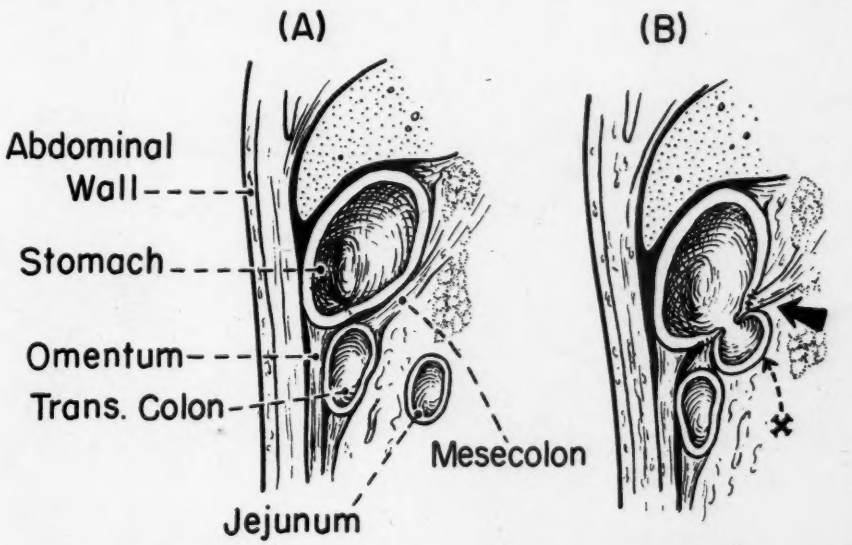
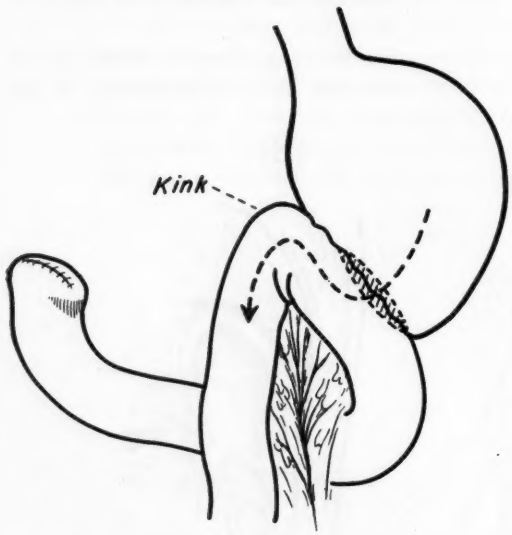


FIGURE V

Cross section through a posterior gastrojejunostomy showing the stomach sutured to the opening in the transverse mesocolon. This gives another point of fixation and possible kinking, in addition to those shown in Figure IV for the anterior gastrojejunostomy.

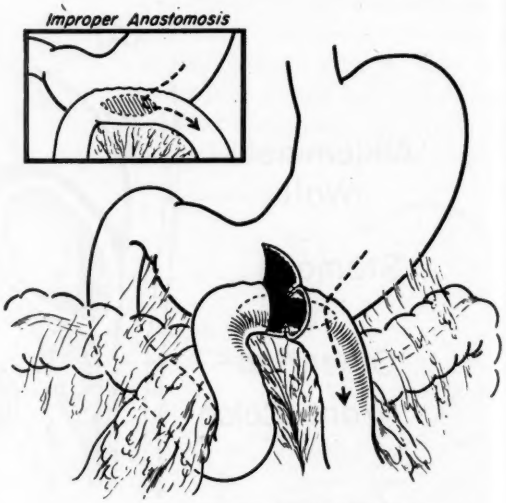
distal loop following either a simple posterior or anterior gastroenterostomy or an anastomosis after any type of resection. Such kinking can and, at times, does produce an obstruction (Fig. VI). Now, we never bring the distal loop of jejunum in a Polya type anastomosis off the lesser curvature of the stomach even though the proximal loop may lie better in this position. As the stomach retracts up beneath the liver and the diaphragm, the distal loop which is directed upward has to turn sharply downward as a result of the position of the anastomosis beneath the liver and as a result of the length of the mesentery of the anastomotic loop (Fig. VII). It is therefore necessarily kinked on itself just distal to the anastomosis. In many patients this causes no difficulty, but an occasional patient may develop a partial obstruction. With this complication the patient does exceedingly well until their fluid intake reaches 75 to 150 cc. per hour. The stomach then fails to empty completely and as it distends, the obstruction becomes more and more complete. Such an obstruction can be relieved temporarily by emptying the stomach and limiting the food intake. However, when drainage is discontinued and the volume of intake is again in-



DISTAL LOOP OFF LESSER CURVATURE

FIGURE VI

Polya type of anastomosis with the distal loop coming off the lesser curvature of the stomach. This we never use, since there is a great possibility of kinking of the distal loop just as it leaves the stomach. This is caused by: (1) the high position of the anastomosis beneath the liver; (2) the fixation of the stomach at the lesser curvature; and (3) the pull on the mesentery of the jejunum as the stomach retracts upward when released following the anastomosis. If kinking and obstruction occur, they can be relieved by an enteroplasty as shown in Figure II.



ANTERIOR ANASTOMOSIS
(Jejunum at right angle to greater curvature)

FIGURE VII

Anterior gastrojejunostomy as performed at Duke Hospital. The proximal loop should not be under tension or acutely angulated. The distal loop should pass directly away from the stomach and not lie more or less parallel to the stomach, as shown in the insert. In the latter, angulation around which the food must pass is shown and this may result in malfunction of the stoma.

creased or as solid food is added to the diet, the obstruction may recur. In my experience this condition has been corrected permanently in every case by an enteroplasty as described above (Fig. II).

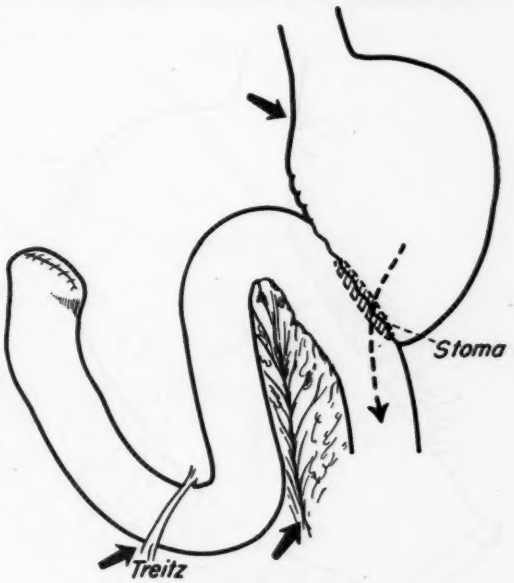
(d) In a gastroenterostomy the distal jejunal loop, if lying parallel to the stomach beyond the site of the anastomosis, may become attached to the stomach by the operative procedure or by adhesions. When this occurs, there is an acute angulation and a spur between the lumen of the stomach and the lumen of the jejunum. As the stomach becomes distended, the functioning of such an anastomosis may be impaired by compression of or tension on the jejunum or by the exaggeration of the spur.

(e) The long axis of the lumen of the efferent loop should pass directly through the opening of the stomach in the gastroenterostomy and should pass away from the stomach at a right angle to the greater curvature in the modified Polya type of anastomosis.

(f) In any type of anastomosis we take every precaution in placing sutures so as not to narrow the lumen of the afferent or efferent loop.

(g) In replacing the structures within the abdomen, we insist on complete relaxation which permits the abdominal wall to be lifted up so that the intestines can be placed as we desire them to lie. The efferent loop of jejunum is placed for as great a distance as possible from the stomach without angulation and this relatively straight course is ended in as gentle a curve as possible.

(h) Finally, in order to avoid fixation by adhesions, the anastomosis and the traumatized area are separated from the anterior abdominal wall by omentum. In this latter procedure care must be taken to avoid any pressure on or kinking of the proximal or distal jejunal loop. If the proximal jejunal loop is completely obstructed by kinking, duodenal contents will regurgitate into the stomach in the presence of a simple gastroenterostomy, but in the presence of a resection either the duodenal stump will blow out or the bowel will perforate from tension necrosis. However, fol-



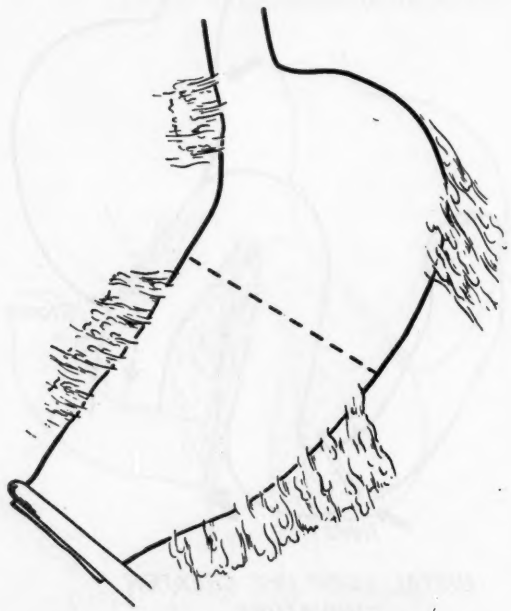
DISTAL LOOP OFF GREATER CURVATURE

FIGURE VIII

Hofmeister modification of the Polya anastomosis. We prefer this operation in resections of the stomach. The end of the stomach is closed except for 4–5 cm. at the greater curvature where the gastrojejunostomy is performed. The distal end of the jejunum passes away from the stomach at a right angle to the greater curvature. The proximal loop is sutured to the closed end of the stomach for a short distance toward the lesser curvature. Some feel that this lessens the chance of passage of food into the proximal loop. It seems to us that with the anastomosis performed in this way we have fewer cases of the so-called "dumping syndrome."

lowing resection, moderate kinking of the proximal loop is better tolerated than the same amount of kinking of the distal loop, since in the former there is never more than a trickle of secretions to pass through an angulated area. In contrast, the distal loop must carry additional secretions and all ingested materials.

Explanations of the malfunctioning stoma have been varied, but one of the most widely accepted was based on nutritional disturbances with hypo-proteinemia and resultant edema about the anastomosis. It has always seemed to me that this explanation has been in error in most cases and it has resulted in much harm since it diverted attention from the real mechanical causes of the obstruction. Certainly, with the corrections in the basic surgery noted above, we no longer have obstructions at the stoma and the necessity for prolonged stomach drainage. However, every stomach should be kept empty immediately before, during, and following any operation performed thereon until there is no longer an abnormal residual when the drainage tube is clamped off for several hours with the patient on a liquid diet.



STOMACH CLEANED THOROUGHLY AT ANASTOMOTIC AREA

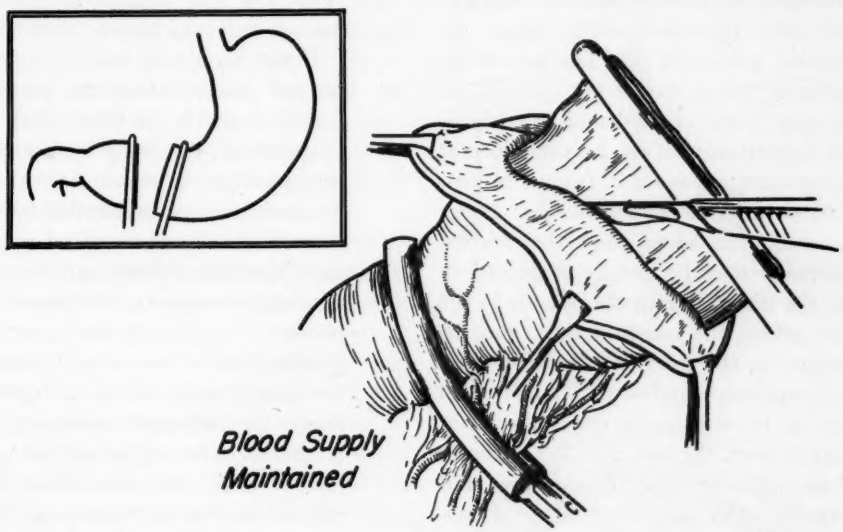
FIGURE IX

Preparing the stomach for resection and anastomosis. The stomach has been divided at the pylorus and the vessels have been divided high on the lesser curvature. All vessels entering and leaving the stomach on both the lesser and greater curvature have been divided and all fat has been removed for 5–6 cm. above the point of resection. This permits a good closure and anastomosis, and following this we have never seen a slough from an inadequate blood supply to the line of resection.

III. In all resections of the Polya type we use the Hofmeister modification (Fig. VIII) closing the end of the stomach beginning at the lesser curvature except for 4 to 5 cm. adjacent to the greater curvature which is used for the anastomosis. We have never had trouble with leakage where the three suture lines come together and the farther we get away from the lesser curvature of the stomach, the less fixation we have at the anastomotic site (Fig. IV). We obtain a high ligation of the branches of the gastric vessels on the lesser curvature, clean off all fat and ligate all vessels as they enter or leave the stomach wall along the lesser and greater curvatures for 4–6 cm. above the line of resection (Fig. IX). This gives a clean stomach wall for suture, in my experience has never resulted in a deficient blood supply to the resection area, and enables us to get a good closure of the lesser curvature and to perform an anastomosis without danger of leakage. With the smaller anastomosis (Fig. VIII), and with the proximal loop of jejunum overlapping part of the closed end of the stomach and possibly forming a valve like mechanism to prevent forcing of stomach contents into the prox-

imal loop as claimed by some, it seems that we have less trouble with the so-called "dumping syndrome."

IV. Postoperative hemorrhage of any severity is almost a thing of the past. We make no attempt at operation to ligate the individual bleeding points, but depend on the sutures of a three layer anastomosis to control bleeding. The development of the very fine catgut on atraumatic needles enables us to place the sutures very close together without undue trauma and without leaving a large amount of foreign material in the suture line. For the two inner suture lines we use continuous five 0 chromacized catgut. In order to obtain better hemostasis the middle suture picks up all layers of the wall of the stomach and jejunum except the mucosa and the inner suture not only approximates the mucosa, but obliterates the dead space and cleavage plane between the mucosa and the submucosa. The outer suture of triple 0 chromic catgut approximates serosa to serosa and inverts the middle suture line. This is reinforced at the angles with a few interrupted sutures of fine silk or cotton. The end of the stomach



REMOVAL OF ANTRAL MUCOSA IN EXCLUSION OPERATION

FIGURE X

Method of performing an exclusion type of resection as performed at Duke Hospital. The insert shows the point of division between two crushing clamps. The antrum is freed down to or below the pylorus if the location of the ulcer permits, but the blood supply to the stomach along either the lesser or greater curvature is kept intact to avoid necrosis of the antral stump of the stomach. A non-crushing intestinal clamp has been placed across the blood supply and duodenum so as to control bleeding and back flow of intestinal contents. An incision has been made distal to the crushing clamp and through the wall of the stomach down to the mucosa. The mucosa is being freed down to the pylorus. The mucosa is then cut across and closed with a continuous suture of catgut. A second continuous suture is used to close the antral wall from within, just above the mucosal closure. A number of similar sutures obliterate the muscular and submucosal funnel to near the cut end. The cut end is then inverted if space permits. We have had no hemorrhage following such a closure and no leakage except in the presence of a slough from inadequate blood supply.

toward the lesser curvature is closed with two inner sutures of continuous triple 0 chromacized catgut and an outer layer of interrupted fine silk or cotton sutures.

V. The duodenal stump is closed with two inner continuous sutures of triple 0 chromacized gut and one or two outer layers of interrupted fine silk or cotton. We may use a clamp and an inverting suture of the Parker-Kerr type if there is adequate length of duodenum. If the amount of duodenum for inversion is limited, we do not use a crushing clamp, but close first the mucosa, then approximate the submucosa and muscular wall over this and finally place the inverting sutures of silk. Leakage of the duodenal stump should not occur if an adequate length of duodenum is available and if obstruction of the proximal loop at the stomal site is avoided. It must be kept in mind when determing whether or not to resect the ulcer that the scarred duodenum may be greatly shortened so that the distance from the pylorus to the point where the common duct may be damaged is not great. The surgeon must have experience and sound judgment in order to know when to resect the ulcer, when to resect through the ulcer, when to do an exclusion type of operation and leave the ulcer and when to do a gastroenterostomy, with or without a vagotomy. I would not advise a vagotomy unless the surgeon is familiar with the problems of the paralyzed stomach.

If an exclusion operation is decided upon (Fig. X), the blood supply to the pyloric stump of stomach should be left intact on either the lesser or greater curvature to insure against necrosis and subsequent leakage, a complication which I had on two occasions before taking this precaution. In both cases the end of the stomach sloughed and the resultant condition was handled by inserting a tube into the duodenum as described below. Both of the patients recovered.

If during resection sufficient duodenum cannot be obtained to be sure of a good closure and the ulcer has already been opened into, the situation can be met by inserting a large drainage tube into the duodenum and placing a pursestring suture around the duodenum to secure a watertight closure around the tube. This tube is brought out through a stab wound in the right subcostal area. A small suction tube is inserted into the large tube and the secretions removed by suction as fast as they accumulate.

If the duodenum has been closed and for any reason during the postoperative period there is duodenal leakage, the diagnosis must be made early and treated by immediate operation. At that time the situation can best be handled by inserting a drainage tube as described above. It is rare that the blown out or sloughed duodenal stump can be closed in the presence of the extensive reaction. The duodenal secretions must be sucked off continually and it may be desirable to drain the adjacent peritoneal cavity. If there is obstruction of the proximal jejunal loop, this obstruction must be relieved so that peristalsis can carry the secretions down the small intestine and allow the external fistula to close. At the time of the emergency operation provision should be made for prolonged tube feeding of the patient by passing a tube through the abdominal wall, into the stomach, through the anastomosis, and well down into the jejunum. The duodenal, pancreatic and biliary secretions that are aspirated from the duodenum can be reinjected into the jejunum. This will simplify the maintenance of electrolyte balance. Suitable food can be fed into the

jejunum through this tube so that regurgitation through the duodenal stump is less likely to occur than when the food is given into the stomach. After the drainage tract from the duodenal stump to the outside is well established and small, the tubes extending into the duodenum can be gradually withdrawn.

VI. In resections severe damage to the head of the pancreas may have been caused by pre-existing deep penetration of the ulcer, or may be produced by surgical damage to one of the ducts at the time of operation. Under any circumstance, if there is a possibility of pancreatic or biliary drainage, it is imperative that an adequate drainage tract to the outside be established. Otherwise, a fatal chemical and bacterial peritonitis may follow. If such drainage to the outside is provided, drainage of pancreatic secretions is not likely to produce serious consequences.

VII. In operating for duodenal ulcer the common duct is the most frequently damaged of the important structures. However, such an accident is still rare, but when it occurs, it is one of the most serious complications we encounter in the treatment of duodenal ulcer by resection. If one remembers the great shortening of the duodenum that occurs after recurring ulcerations extending over many years, watches carefully the distance from the operative area to the Foramen of Winslow, remembers that the duct passes far over behind the duodenum, performs an exclusion operation or gastroenterostomy with or without vagotomy in the cases with extensive induration surrounding the ulcer, and if in doubt at any time as to the relationship of the duct to the operative area, he opens the common duct and inserts a sound, this complication can usually be avoided. If not avoided, it can be recognized at the time of operation. After it once occurs and if not recognized at the time of operation, it may be difficult to relieve and the mortality is high. When possible, the flow of bile into the intestine should be restored at the earliest possible time.

VIII. Wound disruption is far more likely to occur following gastric surgery than after laparotomy for other conditions. The likelihood of this complication may be diminished by careful closure, the essential points of which are (1) accurate peritoneal

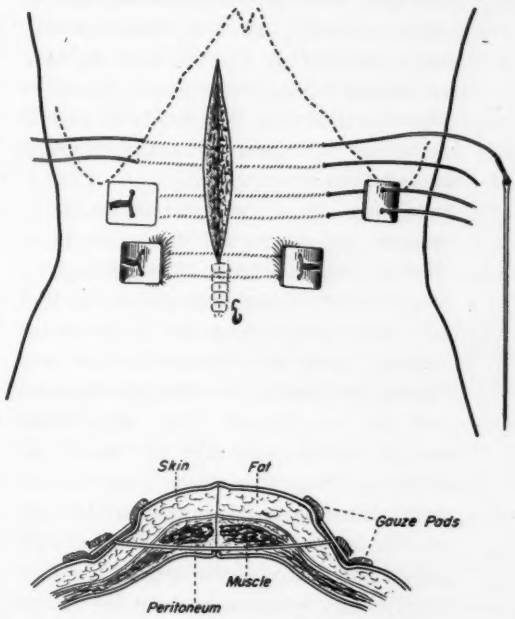


FIGURE XI

Method of closure of the abdominal wall to reduce the chance of wound disruption. Wire sutures on long needles have been passed straight through the abdominal wall from side to side at right angles to the incision and they pass just superficial to the peritoneum at the line of incision. These are inserted with the fingers in the peritoneal cavity to insure against penetration of the peritoneum. The incision is closed in the usual manner after these tension sutures have been inserted but before they are tightened. The ends of the wire are then passed through holes in metal plates, drawn tight to take all tension off the suture line and twisted as shown. No wound so closed has disrupted where the tension was carried on such wires and plates. There is no cutting, since the metal plates are padded and bear the tension on a large area of skin.

approximation, (2) accurate closure of the posterior rectus sheath as a separate layer from the peritoneum when there is a large amount of properitoneal fat, and (3) careful closure of the anterior sheath of the rectus, preferably with non-absorbable silk or cotton. If we limit the use of non-absorbable sutures and ligatures to the anterior sheath and the more superficial tissues, we can meet the situation if infection occurs by providing early drainage. Then, after about two weeks, the skin and subcutaneous fat can be opened widely, all the non-absorbable material removed, and the skin can then be strapped together or closed loosely to allow for drainage. However, with careful technique and the use of antibiotics such an infection is very rare.

In our hands the greatest single insurance against wound disruption is to place a series of tension wires passing in a straight line through the abdominal wall from side to side posterior to the rectus muscles, anterior to the peritoneum, and bearing the tension on metal plates placed well out to the side (Fig. XI). These sutures do not cut, take all tension off the suture line and in the presence of poor nutrition or bacterial contamination time can be allowed for slow healing with almost no chance of disruption. Needless to say, they must be inserted before the peritoneum is closed and with the fingers inside the peritoneum to guard against penetration of the peritoneal cavity.

IX. The development of the very small tubes for stomach drainage or intestinal intubation that can be left in for several days has resulted in one of the great technical advances, applicable not only in the surgery of peptic ulcers but in the entire field of abdominal surgery. However, with improved functioning of the anastomoses it is no longer necessary to use any of the many specialized types of tubes that have been designed for draining the proximal loop, for feeding into the distal loop, for splinting the area of the anastomosis, etc. The need for these devices has to a great extent been eliminated by improvements in the basic surgery. As a matter of fact, I much prefer to avoid the irritation of a tube passing through any anastomotic opening, and like to get the indwelling stomach tube out of the nose and esophagus as early as possible. However, if the functioning of the anastomosis is not perfect, continuous drainage of the stomach can get us out of difficulty in most cases.

Four problems demand special consideration. These are (1) perforation, (2) hemorrhage, (3) advanced obstruction with starvation and (4) the postoperative marginal ulcer with the occasional gastrojejunocolic fistula.

1. In the presence of a perforation into the free peritoneal cavity, the majority of surgeons will undoubtedly operate at the earliest time. While there have been reports of cures by continuous suction to keep the stomach empty, the surgeon who has seen the frequency with which secretions can collect in the stomach with resultant vomiting in the presence of an indwelling suction tube cannot be too confident of his ability to keep the stomach empty. As for the operative treatment, the stoppage of the leak is the most essential, but it should be emphasized that the closure must be secure and the pylorus must not be obstructed. Under no circumstances should Banthine or a similar drug be given. During my residency I treated most of these patients with closure and a posterior gastroenterostomy. In recent years I have treated them by resection. In no such case have I seen untoward results to be ascribed to the resection. As a matter of fact, in the free perforations, the ulcer is anterior and frequently the resection is easier than many

of the resections performed in the absence of a perforation but with a posterior penetration into the pancreas. The closure of the duodenal stump is usually more secure than the closure of the perforation without resection. With better functioning stomas, better control of infection and all other factors making for safety, resection in the presence of an acute perforation is in many cases the operation of choice.

2. Acute hemorrhage is treated conservatively in the Duke Hospital using enough blood to maintain a reasonable blood pressure for the patient. If there is continued or repeated hemorrhage, the blood volume is brought up to near normal and the ulcer is resected if possible. The bleeding is controlled and the continuity of the gastrointestinal tract is restored.

   Where there is no acute hemorrhage, but the patient gives a history of repeated episodes of bleeding, frequently with other symptoms of activity of the ulcer, we advise a resection without waiting for another hemorrhage.

3. In the presence of severe obstruction with advanced starvation the patient is prepared by the best possible restoration of the fluid, electrolyte, vitamin and protein balance and with adequate transfusion to restore his blood volume. He is then operated on using the type of operation best suited to his condition. In an old patient with a low acidity and in very poor condition, an anterior gastroenterostomy is used. If the patient is in fairly good condition and with a history of an active ulcer, a primary resection may be carried out or, if the ulcer has been very active and the patient is in poor condition, a gastroenterostomy may be performed and a resection may be carried out after his nutritional state has been improved.

4. The early marginal ulcer without obstruction is treated by dietary and medical measures. If relief cannot be obtained and maintained, a vagotomy may be performed. If the lesion has progressed to partial obstruction of the stoma, resection of an additional amount of the stomach may be necessary in order to give an adequate opening. We may depend on the resection of a considerable percentage of the remainder of the stomach or on a vagotomy to diminish the chances of a further recurrence of the marginal ulcer.

   In the presence of a gastrojejunocolic fistula which frequently is associated with an advanced stage of malnutrition, it is imperative that the patient be gotten in the best possible condition, that the anastomosis be taken down, and the opening in the colon closed. Then, depending on the condition of the patient, we may carry out a resection, or, if the patient's condition is very poor and the pyloric opening is adequate following an old gastroenterostomy, we may close the openings in the stomach and jejunum and hope to improve the patient's general nutrition before attempting a resection.

I would like to summarize at this point how we handle the more likely complications following gastric surgery, all of which are now relatively uncommon.

I. Most important of all is to avoid complications by performing good initial surgery and giving good preoperative and postoperative care.
   (a) Do not attempt the impossible, but select an operation that is safest for the existing condition.
   (b) Leave adequate blood supply to the duodenal stump and particularly to the gastric stump if an exclusion operation is performed.
   (c) Control bleeding.
   (d) Control infection by the minimal trauma, the avoidance of undue soiling, the use of suitable antibiotics and maintenance of good pulmonary ventilation.
   (e) Keep the stomach empty by con-

tinuous drainage until gastrointestinal function has been restored.

II. Postoperative hemorrhage:
   (a) With close observation and adequate blood replacement bleeding will stop in most cases.
   (b) If necessary, explore, open the anastomosis, and suture or ligate the bleeding point.

III. Malfunctioning stoma. This condition is always due to an obstruction which is usually partial, but it may be complete.
   (a) Fortunately in recent years it occurs only rarely, is almost always partial and can usually be corrected by drainage of the stomach through an indwelling tube for several days to a week or longer.
   (b) If severe, it can be corrected by an enteroplasty on the jejunum similar to a Finney pyloroplasty. This, of course, would not be performed until a reasonable trial with gastric drainage and then the anastomosis would have healed sufficiently to allow this operation without danger of necrosis of the strip of jejunum between the incisions for the first and second operations.

IV. Leakage of duodenal stump:
   (a) Early diagnosis and immediate operation is imperative if the patient with this complication is to be saved.
   (b) Suitable drainage of the duodenal stump and adjacent peritoneal cavity is necessary.

V. Inability to maintain a normal weight: This complication is best avoided by not removing too much stomach at the time of resection, and accepting a slight increase in the possibility of the development of a marginal ulcer which may necessitate further surgery. We must not make a nutritional cripple in relieving an ulcer cripple. When too much stomach has once been removed, it cannot be replaced and then we can only hope to give some relief by dietary measures.

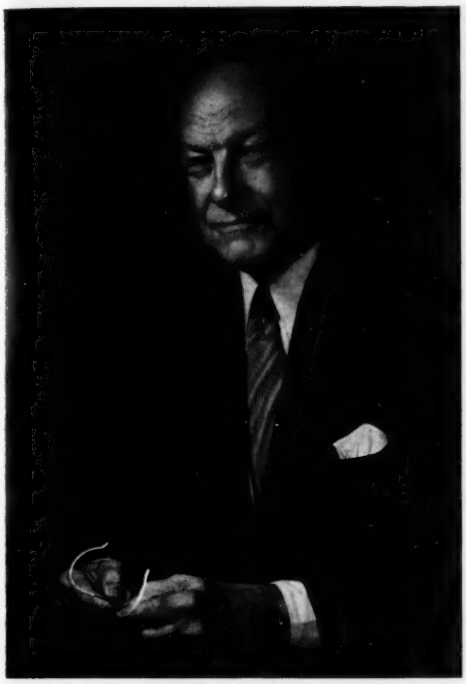
Finally, I would like to emphasize again that at Duke we have made surgery available to that large group of patients whose only indication for operation is that they cannot live in reasonable comfort and happiness with their ulcer. Since we can give very satisfactory relief to over 85% of patients, can make life more tolerable for another 8–10% and have only 3–4% develop marginal ulcers, and with the present very low operative mortality, it is no longer necessary for the ulcer patient to give up his occupation in which he can make a good income to care for his family and make a financial cripple out of himself in order to exist with his ulcer.

In conclusion I would like to say that there are many surgeons of today who can get better results in operations for peptic ulcers than the giants of yesteryear. However, lest we become egotistical we must remember always that the procedures we use have been built on the firm foundations provided by the few who pioneered in and suffered the heartaches of the exploration of new fields. Without the knowledge obtained by their courage and experiences we would have had to make our way through unknown fields instead of following a well established highroad in which our contribution has been literally the elimination of a few sharp curves and obstructions.

Duke University Hospital
Durham, North Carolina

ARE WE AFRAID TO FACE THE FACTS[1]

ELMER HESS, M.D.[2]



ELMER HESS, M.D.

Mr. President, Ladies and Gentlemen, I have been asked by three or four people to tell a story. I'm a little bit afraid to tell this story but here goes.

I've been asked to tell the story about the dandelions. Now, I have a censor out in the audience and I'm going to catch it for this story, believe me, but I have a lawn (about four and a half acres) up in Erie, and some twenty or thirty years ago I used to take my exercise by putting on an old, dirty sleeveless shirt and an old dirty hat (I've been as bald as I am now for a good many years), and digging dandelions out of the lawn.

One day I was at my favorite avocation when a limousine drove up with a chauffeur, and a very sweet voice said, "My man, will you please stop and come over here." And I came hither. She said: "Do you keep this lawn looking like this all by yourself?" I said, "Yes m'am." I paid for it and I didn't consider that I was lying.

She said, "Who lives here?" I said, "A chap by the name of Dr. Hess." She said, "I've heard of him. What sort of a chap is he anyway?" I said, "Well, madam, he is pretty much of a so-and-so, but I've got to earn a living." She said, "What does he pay you?" I said, "He is not very liberal, he only gives me one hundred dollars a month and my board." She reached into her pocketbook, took out a card, handed it to me and said, "Any time you wish to change employers, I'll give you one hundred fifty dollars a month and your board." And I said, "yes, m'am, but . . . ," and she said: "But what, my man?" I said, "Madam, here I have the privilege of sleeping with the lady of the house." And with that she said: "Drive on, James."

Now, there is a sequel to this story and since there is an Anglican Priest sitting at the head table, and I happen to be one of those who also flunked his Latin, I'll tell you the sequel. I'll tell you exactly what I am.

About a year after that, I was invited to a wealthy little City near where oil was discovered, to speak before the local Rotary Club. They hold the Rotary Club meetings in this little city in the Parish House of the wealthy Episcopal Church there, and who is waiting on the head table but the lady in the limousine.

I said to myself, I'm clean, I have no hat on, I'm bald and gray, she'll never recognize me, and so I boldly walked up and sat down at the head

[1] I. Ridgeway Trimble Fund Lecture. Presented at the One Hundred and Fifty-seventh Annual Meeting of the Medical and Chirurgical Faculty of the State of Maryland, on Thursday evening, April 21, 1955, Main Ballroom, Sheraton Belvedere Hotel, Charles and Chase Streets, Baltimore 2, Maryland.

[2] President-Elect, American Medical Association.

table between the Parish Priest and the President of the Club. I hadn't been seated more than a moment before a delicate waft of perfume came over my right shoulder and a sweet voice said: "So Dr. Hess is a so-and-so, is he?" Only she didn't say "so-and-so."

Now since we have about identified what I am after Dr. Goldstein's introduction, I would like to be serious with you for a few moments, if I might.

Are we afraid to face the facts, and what are the facts? Well, the facts are that American Medicine has been accused of overcharging. American Medicine has been accused of controlling admissions to our Medical Schools so that a limited number of doctors would be graduated each year, so that we would have no competition. American Medicine has been accused of not being tolerant of any of the quack cancer cures that are so prevalent around the country, and not allowing the so-called cancer cures to be used and experimented with so that we can find out whether or not they are efficacious. The American Medical Association has been accused of a great many, many things and, are they true? Well, I don't think they are.

In the first place, I happen to be President-elect of the A.M.A., and last year I tried to get twenty-three boys into a Medical School. I got four out of the twenty-three. That's not very much influence, is it?

Our Medical Schools can be congratulated for doing two things. One, they can be congratulated because they select their own students without fear or favor and it doesn't matter who the boy is or what he is, if he doesn't measure up to the quality requirements to study medicine, he doesn't get in.

We have also been accused of keeping down the production of medical men. Well, for your information there are ten New Medical Schools that will be sending out graduating classes within the next four or five years. It isn't quantity we want in Medicine, it is quality.

We have also been accused of being one of the strongest Labor Unions in the world. Is that a fact? Of course it isn't. Has the A.M.A., or has your own State Society or your own County Society ever once told you what you could charge or what you couldn't charge for services rendered to a human being? Of course not.

We have created an insurance program, and you heard something of reinsurance last night. We created the Insurance Program first, to fight Socialized Medicine, second, to protect the public. In the beginning we never dreamed that it would benefit us as individuals and it hasn't benefited most of us. The Surgeon and the Surgical Specialist, which I represent, are the men who have benefited financially from the Insurance Program, but the American Medical Association does not favor the benefiting of any group of doctors financially, so we must work out ways and means whereby all medical men may be properly remunerated for the services which they render to the public under our insurance program.

The American Medical Association has recognized that mental health is perhaps the most acute problem presenting itself to American Medicine today, and has the American Medical Association done anything about it? Of course it has. What has been done? It has created a Council on Mental Health within the last year, and you have Leo Bartemeier, right here in your City of Baltimore, who is the Chairman of that Council on Mental Health. Mental health is a program that spends some five hundred million dollars by the United States Government and some five hundred million dollars by State Governments to do what? To put poor, mental wrecks in institutions that are ill-manned, to stay there and wilt, and when it is recognized that the majority of people who are acutely mentally ill can be returned to society and salvaged, it seems to me that it is a disgrace when the American people, and American Medicine in particular, permit such a condition to exist. I am very proud to be able to say to you that my own State has decided to spend some

thirty-five million dollars on the Mental Health Program, but there has been no research in mental health worthy of the name.

A measly six million dollars has been spent yearly on research in this very important field, and with the stresses and strains of modern life, more and more of us become at times acutely ill mentally. Mental health is really one of our biggest problems. It is much bigger than the Polio problem and yet we are accused again of doing things for our own personal benefit.

I would like to say to you that I was in Ann Arbor when Salk made his report, on the Salk Vaccine. I have never seen a more modest, self-effacing fine little gentleman in my life than Salk, and what an example! People have been sending money to him—large sums of money to him. What has he done with the money? Did he put it in his pocket? No, he set it aside for research in virus diseases. The man could be a multi-millionaire if he were a quack, but because he is a decent physician, doing research work, he has given of his knowledge freely and frankly to his profession so that they may help other people benefit from his work. We should be very proud of men of this caliber.

The American Medical Association is you. Anything that happens at Chicago starts at the County Society level, goes from the County Society level by majority vote to the State Society level and there by majority vote it is either killed or goes to the national level, and whenever we at the national level do anything, it is because you have demanded that we do it. This is the one democratic organization that I know of in America whose orders come from the grass roots. They do not come from the top down. Again we differ from the labor union movement in that respect.

A short time ago the American Medical Association revamped its Code of Ethics, and I was a little bit amazed to find that you could revamp a Code of Ethics. To me, there is only one fundamental principle involved in our Code of Ethics and that is that decent doctors take care of sick people. That is the only principle in our Code of Ethics. The rest of it are rules of etiquette by which we should be guided in our contacts with each other and the public. You can compromise everything but a fundamental principle. You can never compromise your fundamental principles.

Somebody has said to me (for example) why are you opposed to reinsurance? Well, I'll tell you one reason why I'm opposed to it. There is a rehabilitation program that is sponsored by the Federal Government. No one can operate on anybody for a hernia that is referred in that rehabilitation program unless he is a certified specialist in surgery. That is a dictate by the Federal Government for the fees that are to be paid out of Federal monies to care for people whom the Federal Government wishes to rehabilitate in this Federal program. Yet, you can't tell me, with sixty-five per cent of the surgery in America being done by men who are not Fellows of the American College of Surgeons, and who are not certified, that there aren't thousands of fine surgical operators who cannot operate on any patients for whom the Federal Government pays a fee.

Wherever you have Federal subsidy, you have Federal control because when you pay the bill you say how the money shall be spent and for what, and the Federal Government again is you, believe it or not.

I have been impressed as I have gone around the country with the philosophy of the doctors with whom I have had the privilege of speaking. I told you that I had flunked my Latin. I was born and raised an Episcopalian. I don't work at it very hard, but I do work at practicing medicine very hard, and I am completely convinced in my own mind that it is very difficult to be a good physician unless you believe in something besides abstract science.

If I had a criticism of medical education today, it would be that our medical schools teach science and have forgotten the humanities, and I think it is pretty nearly time that we demanded that

our medical schools put the humanities back into the curriculum so that when we teach young men to take care of the sick, we also teach them to take care of something else. A person cannot be physically sick without being mentally disturbed, and faith and hope are things we can give to many patients for whom we have little to offer scientifically.

I would like to tell you a personal experience if I might. A number of years ago I was asked to see a desperately ill woman who had an inoperable cancer of the bladder. I went in to see her one day and she said I am very grateful, Dr. Hess, that I have a Christian gentleman as my physician. Well, I knew there was only one man in the whole world who would call me both of those in the same sentence, and it happened to be the Episcopalian Bishop in my area, Bishop John Ward. I said, "Bishop Ward is your Bishop, isn't he?" She said "Yes he is, and he tells me what a wonderful Church man you are." I told him when he was alive that I thought that he ought to go to confession for that one. She said to me, "Would you say some prayers with me"? I said "Sure, where is your prayer book?" She handed me her prayer book and I knelt by the side of her bed. My grandmother wanted me to be an Anglican Priest and she was terribly disappointed when I became a physician, and as I began to say these old, familiar prayers, I didn't have to look at the book, the old brain just kept winding them out, much to my own amazement.

Suddenly I looked up and in the doorway of the room stood the nurse who was taking care of this particular woman. She disappeared and shortly after that there must have been twenty nurses in that doorway. The patient couldn't see them but I could. They were looking at Dr. Hess on his knees praying. When I got through, the old lady thanked me very much. I left the room. All the other nurses disappeared but the nurse taking care of the patient and I knew she was dying to say something to me, so finally I said, "Well, Sally, spit it out, what's on your mind?" She said: "Dr. Hess, do you know you really knew those prayers and I never even knew before today that you were a Christian. You know I've heard you when you got mad in the operating room, not once, but many times?" And I said, "Sally, what you have just seen is the best medicine you have ever seen me practice, the best therapeutics that I have practiced in a long time," and I went down and I wrote some orders. "The morning nurse will say morning prayers with the patient, the afternoon nurse will read a psalm to the patient, and the evening nurse will say evening prayers with the patient," and I made them do it, too, don't you think I didn't.

Now there is a moral to that story. The surprising thing is that from that day on, that woman suffered her anguish and her pain without ever once asking again for an opiate. One day I went in and said, "Listen, you don't have to suffer. We'll give you all the morphine you need to relieve your pain." She said, "Doctor Hess, I don't want any. I want a clear mind when these three Christian women pray with me," and that woman, for whom we could do nothing died with a humanitarian service for her last six weeks. Our Medical Schools should teach that sort of thing, in my book.

I don't ask you to be a good Episcopalian or a good Catholic or a good Methodist; I don't ask you to be a good Jew or a good Mohammedan; I ask you to believe in a Creator, and after the atomic tests out on those flats in Nevada, and the bombs that were dropped on Hiroshima, how anyone can dispute that something created the whole business is beyond my power of comprehension. I ask you to believe in the Fatherhood of God and the Brotherhood of man.

In closing, I am going to ask each one of you to answer the question as an individual. Can you face the facts? When you get up in the morning to shave, can you look in that mirror and say "I have lived a clean and decent yesterday." Can you say: "I did everything I could do to alleviate human suffering yesterday and last night?" Can you say: "I have fought the fight,

maintained my faith in my ability to save life if possible, but to alleviate human suffering always?"

You are the American Medical Association.

501 Commerce Building
Erie, Pennsylvania

DR. YEAGER: Thanks, very much, Dr. Hess. It was done beautifully. It gives me a great deal of pleasure to present to you in appreciation for that very fine address, the I. Ridgeway Trimble Memorial Medal and Honorarium. Thanks again.

SOCIAL SECURITY AMENDMENTS

The AMA Washington Letter, No. 84-26

The House Ways and Means Committee on June 21 started closed hearings on legislation proposed by Democrat members of the committee for extension of social security benefits. The Democrats' bill calls for lowering the age for payment of benefits to women from 65 to 62, payments to disabled children past 18 years of age, and a system of cash payments for disability. Republican members, in a letter to Chairman Jere Cooper, objected to the hurry-up procedure, particularly when the Democrats' announcement was "silent as to any plans for financing these changes." The Republicans pointed out that the program would cost around $2 billion a year, to come out of the OASI Trust Fund. "We of the Republican party," the letter said, "are deeply concerned over the problem of disability and the fairest possible treatment of women under the Social Security Act. We are equally concerned that the future retirement and security survivorship protection of today's workers and their families not be jeopardized by dissipation of the Social Security Trust Fund." Secretary Hobby also objected to the Democrats' decision against open hearings. In a letter she reminded Mr. Cooper that the Social Security Act was extensively amended last year, but only after long study of all the problems. She said that another careful study should be made before any more changes are made.

The American Medical Association addressed the following telegram to Mr. Cooper, Speaker Rayburn, House Minority Leader Martin, and Rep. Thomas A. Jenkins, ranking minority member of the Ways and Means Committee: "The American Medical Association is disturbed by press reports indicating that the majority of the Committee on Ways and Means has decided to act without public hearings on major changes in the Social Security Act. The proposals discussed embody significant changes in public policy. We see no justification for hasty action, and urge you to use your good offices to assure public hearings before undertaking a program with so many serious ramifications."

On the Senate side, there is not the same enthusiasm for speedy enactment. Chairman Byrd of the Finance Committee has ordered a staff study of the costs of the proposed amendments, and says he will not take a position until the cost figures are available.

Semiannual Meeting

MEDICAL AND CHIRURGICAL FACULTY

FRIDAY, SEPTEMBER 16, 1955—OCEAN CITY, MARYLAND

The Committee on Scientific Work and Arrangements, in conjunction with the Worcester County Medical Society, has planned a most interesting meeting for Friday, September 16, 1955 at the Commander Hotel in Ocean City. At this time arrangements have not been completed, but following are some of the highlights of the Meeting.

HEADQUARTERS—COMMANDER HOTEL

BUSINESS SESSIONS

COUNCIL ..... Thursday, September 15, 8:30 P.M.
HOUSE OF DELEGATES ..... Friday, September 16, 9:30 A.M.

PROGRAM—FRIDAY, SEPTEMBER 16

CLAM BAKE ..... 1:00 P.M.
On Beach in front of Commander Hotel

SCIENTIFIC SESSION AND GENERAL MEETING ..... 2:30 P.M.
Beach Lounge, Commander Hotel

"OCEAN" CRUISE OR MINIATURE GOLF TOURNAMENT ..... 2:30 P.M.

DANCE ..... 9:00 P.M.
Commander Hotel

WOMAN'S AUXILIARY MEETING ..... 10:30 A.M.
Social Room, Commander Hotel

It is hoped that you and your family plan to attend this Meeting with its attractive social functions and informative scientific and general meetings.

DIRECTORY*

MEDICAL AND CHIRURGICAL FACULTY OF THE STATE OF MARYLAND

March 31, 1954–May 31, 1955

LIST OF PRESIDENTS—1799–1955

1799–1801—Upton Scott.
1801–1815—Philip Thomas.
1815–1820—Ennals Martin.
1820–1826—Robert Moore.
1826–1836—Robert Goldsborough.
1836–1841—Maxwell McDowell.
1841–1848—Joel Hopkins.
1848–1849—Richard Sprigg Steuart.
1849–1850—Peregrine Wroth.
1850–1851—Richard Sprigg Steuart.
1851–1852—William W. Handy.
1852–1853—Michael S. Baer.
1853–1854—John L. Yeates.
1854–1855—John Fonerden.
1855–1856—Jacob S. Baer.
1856–1857—Christopher C. Cox.
1857–1858—Joshua I. Cohen.
1858–1859—Joel Hopkins.
1859–1870—Geo. C. M. Roberts.
1870—John R. W. Dunbar.
1870–1872—Nathan R. Smith.
1872–1873—P. C. Williams.
1873–1874—Charles H. Ohr.
1874–1875—Henry M. Wilson.
1875–1876—John F. Monmonier.
1876–1877—Christopher Johnston.
1877–1878—Abram B. Arnold.
1878–1879—Samuel P. Smith.
1879–1880—Samuel C. Chew.
1880–1881—H. P. C. Wilson.
1881–1882—Frank Donaldson.
1882–1883—William M. Kemp.
1883–1884—Richard McSherry.
1884–1885—Thomas S. Latimer.
1885–1886—John R. Quinan.
1886–1887—George W. Miltenberger.
1887–1888—I. Edmondson Atkinson.
1888–1889—John Morris.
1889–1890—Aaron Friedenwald.
1890–1891—Thomas A. Ashby.
1891–1892—William H. Welch.
1892–1893—L. McLane Tiffany.
1893–1894—George H. Rohé.
1894–1895—Robert W. Johnson.
1895—J. Edwin Michael.
1895–1896—Charles G. Hill.
1896–1897—William Osler.
1897–1898—Charles M. Ellis.
1898–1899—Samuel C. Chew.
1899–1900—Clotworthy Birnie.
1900–1901—Samuel Theobald.
1901–1902—J. McPherson Scott.
1902–1903—William T. Howard.
1903–1904—Eugene F. Cordell.
1904–1905—Edward N. Brush.
1905–1906—Samuel T. Earle, Jr.
1906–1907—Hiram Woods.
1907–1908—Charles O'Donovan.
1908–1909—Brice W. Goldsborough.
1909–1910—G. Milton Linthicum.
1910–1911—Franklin B. Smith.
1912—Hugh H. Young.
1913—Archibald C. Harrison.
1914—Randolph Winslow.
1915—J. W. Humrichouse.
1916—J. Whitridge Williams.
1917—Guy Steele.
1918—William S. Halsted.
1919—John Ruhräh.
1920—James E. Deets.
1921—William S. Gardner.
1922—Arthur H. Hawkins.
1923—Herbert Harlan (Jan.–Aug.).
Harry Friedenwald (Aug.–Dec.).
1924—Philip Briscoe.
1925—Lewellys F. Barker.
1926—Thomas B. Johnson, Deceased December 25, 1925.
1926—Josiah S. Bowen.
1927—Thomas S. Cullen.
1928—Peregrine Wroth, Jr.
1929—Alexius McGlannan.
1930—Henry M. Fitzhugh.
1931—J. M. H. Rowland.
1932—Eldridge E. Wolff.
1933—J. Albert Chatard.
1934—George O. Sharrett.
1935—J. M. T. Finney, Sr.
1936—Frederick D. Chappelear.
1937—Arthur M. Shipley.
1938—Frank B. Hines.
1939—Dean Lewis: Acting President, Victor F. Cullen.
1940—Edward P. Thomas.
1941—Harvey B. Stone.
1942—R. Lee Hall.
1943—Charles R. Austrian.
1944—Jacob W. Bird.
1945—Carroll Lockard.
1946—Thomas R. Chambers.
1947—William T. Hammond.
1948—Charles W. Maxson.
1949—W. Houston Toulson.
1950—A. Austin Pearre.
1951—Walter Dent Wise.
1952—Alan M. Chesney.
1953—Maurice C. Pincoffs.
1954—Bender B. Kneisley.
1955—George H. Yeager.

LIST OF VICE-PRESIDENTS

1799–1848—(Unknown.)
1848–1849—John Readel, Jacob Baer, P. Wroth.
1850–1851—Joel Hopkins, P. Wroth, Jacob Fisher.
1851–1853—(Unknown.)
1853–1854—John Fonerden, Albert Ritchie, P. Wroth.
1854–1855—Geo. C. M. Roberts, Samuel P. Smith, Joel Hopkins.
1855–1856—George C. M. Roberts, G. W. Miltenberger, M. Diffenderffer.
1856–1857—P. Wroth, Wm. H. Davis, Samuel Smith.
1857–1858—William Waters, Frederick Dorsey, Joel Hopkins.
1858–1859—Samuel Chew, Stephen N. C. White, Samuel K. Handy.
1859–1863—John R. W. Dunbar, Samuel Chew, Wm. M. Kemp.
1863–1871—John R. W. Dunbar, Wm. M. Kemp, John C. Hopkins.
1871–1872—C. H. Ohr, Edward Warren, Richard McSherry.
1872–1873—(Unknown.)
1873–1874—Samuel Chew, H. M. Wilson, A. B. Arnold.

* Transactions, 1955.

1874–1875—Francis T. Miles, James A. Steuart, D. A. O'Donnell.
1875–1876—Christopher Johnston, A. B. Arnold, J. C. Thomas.
1876–1877—P. C. Williams, James A. Steuart, Francis T. Miles.
1877–1878—S. C. Chew, F. E. Chatard, Charles H. Jones.
1878–1879—James C. Thomas, L. McLane Tiffany.
1879–1880—H. P. C. Wilson, James A. Steuart.
1880–1881—L. McLane Tiffany, G. Ellis Porter.
1881–1882—A. H. Bayly, I. E. Atkinson.
1882–1883—Thomas S. Latimer, Richard McSherry.
1883–1884—W. Stump Forward, J. S. Lynch.
1884–1885—John R. Quinan, I. E. Atkinson.
1885–1886—E. C. Baldwin, J. E. Michael.
1886–1887—Thomas Opie, Richard Gundry.
1887–1888—Charles H. Jones, James Carey Thomas.
1888–1889—J. E. Michael, Thomas P. Evans.
1889–1890—T. A. Ashby, C. G. W. Macgill.
1890–1891—Geo. H. Rohé, J. McPherson Scott.
1891–1892—J. W. Humrichouse, David Streett.
1892–1893—J. W. Downey, J. W. Chambers.
1893–1894—John D. Blake, John S. Fulton.
1894–1895—Charles H. Jones, W. M. Nihiser.
1895–1896—Charles G. Hill, Clotworthy Birnie.
1896–1897—Wilmer Brinton, Randolph Winslow.
1897–1898—W. F. A. Kemp, George J. Preston.
1898–1899—Mary Sherwood, J. McPherson Scott.
1899–1900—Samuel Theobald, David Streett.
1900–1901—Samuel T. Earle, Jr., J. B. R. Purnell.
1901–1902—Harry Friedenwald, B. W. Goldsborough.
1902–1903—Samuel T. Earle, Jr., Wilmer Brinton.
1903–1904—Franklin B. Smith, James M. Craighill.
1904–1905—Samuel T. Earle, Jr., D. C. R. Miller, Julius A. Johnson.
1905–1906—Charles O'Donovan, Thomas M. Chaney, Joseph B. Seth.
1906–1907—William T. Watson, Philip Briscoe, William F. Hines.
1907–1908—Roger Brooke, Henry L. P. Naylor, George Dobbin.
1908–1909—Philip Briscoe, William L. Smith, G. Milton Linthicum.
1909–1910—Philip Briscoe, A. P. Herring, Compton Riely.
1910–1911—J. Staige Davis, H. B. Gantt, Timothy Griffith.
1912—J. L. Riley, D. E. Stone, J. A. Chatard.
1913—J. Staige Davis, C. F. Davison, E. B. Claybrook.
1914—C. R. Winterson, A. L. Franklin, Gordon Wilson.
1915—A. McGlannan, J. E. Deets, R. Lee Hall.
1916—L. C. Carrico, M. D. Norris, J. A. Chatard.
1917—D. E. Stone, A. H. Hawkins, J. M. H. Rowland.
1918—Julius Friedenwald, J. E. Deets, J. McF. Dick.
1919—J. McF. Bergland, Philip Briscoe, J. E. Deets.
1920—T. R. Boggs, A. M. Shipley, Eugene Jones.
1921—J. H. M. Knox, Jr., A. H. Hawkins, C. E. Davidson.
1922—Harry Friedenwald, W. R. White, J. S. Bowen.
1923—J. M. H. Rowland, Harry Friedenwald, Peregrine Wroth, Jr.
1924—C. Urban Smith, J. Percy Wade, E. E. Wolff.
1925—J. S. Bowen, T. B. Johnson, J. McF. Dick.
1926—Standish McCleary, G. Roger Myers, S. A. Nichols.
1927—Standish McCleary, John L. Riley, Frank S. Keating.
1928—J. Albert Chatard, F. B. Hines, R. T. Miller, Jr.
1929—Henry M. Fitzhugh, Robert P. Bay, Thomas R. Boggs.
1930—F. D. Chappelear, W. T. Hammond, F. B. Hines.
1931—W. D. Campbell, H. M. Lankford, Charles Maxson.
1932—W. T. Hammond, John T. King, Jr., Lewis K. Woodward.
1933—S. A. Nichols, E. H. Hutchins, W. S. Seymour.
1934—G. C. Lockard, W. R. White, J. L. Riley.
1935—J. McF. Dick, Louis Hamman, V. D. Miller.
1936—Harvey G. Beck, Norman S. Dudley, Jesse O. Purvis.
1937—Harvey B. Stone, W. A. Gracie, R. Lee Hall.
1938—Frank S. Lynn, Richard C. Dodson, Everard Briscoe.
1939—Victor F. Cullen, Frederic V. Beitler, William D. Noble.
1940—Edward P. Smith, H. A. Cantwell, Charles L. Owens.
1941—Guy L. Hunner, Charles R. Foutz, R. Lee Hall.
1942—Maurice C. Pincoffs, Wm. F. Williams, Jacob W. Bird.
1943—Charles Reid Edwards, A. Austin Pearre, J. Oliver Purvis.
1944—Alan M. Chesney, William D. Campbell, Hugh R. Spencer.
1945—William N. Palmer, Harry R. Slack, Armfield F. Van Bibber.
1946—William D. Noble, Grant E. Ward, John S. Green, Jr.
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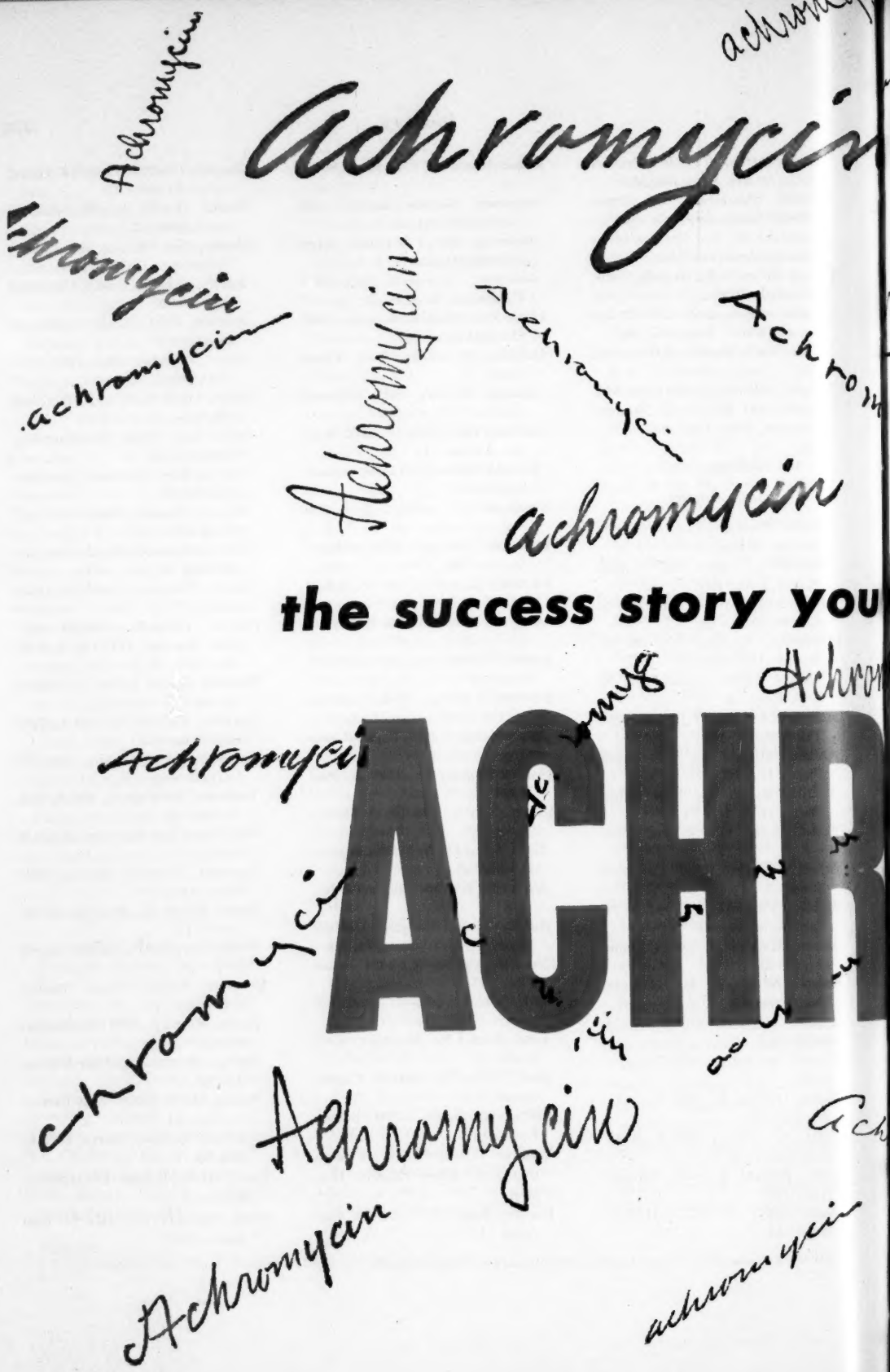
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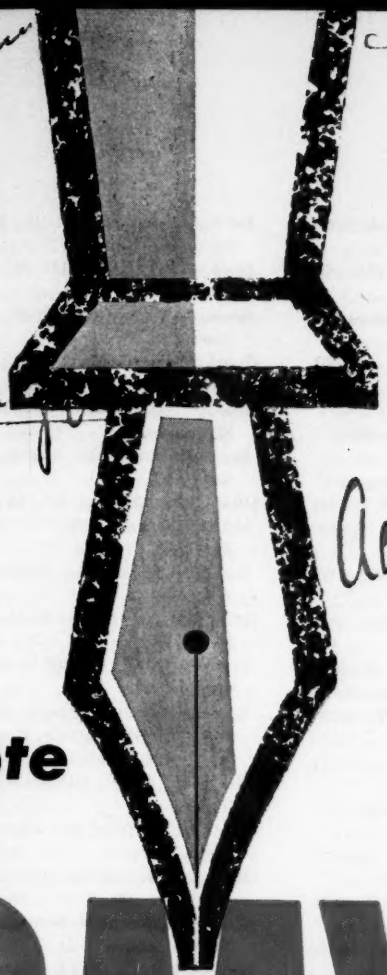

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Cross, Ernest S., Jr., 4408 Atwick Road—10
Cross, Richard J., 104 W. Madison Street—1
Crowe, Samuel J., Tuscany Apts.—10
Crowther, Aloho H., 4209 Frederick Avenue—29
Cumin, Milton H., 4302 Springdale Avenue—7
§Cunningham, Raymond M., 11 E. Chase Street—2
Currie, Dwight McI., 11 E. Chase Street—2
§Curtis, Raymond Miller, 113 Beechdale Road—10
Daly, Harold Lawrence, Jr., 3300 W. North Avenue—16
Daly, Miriam Shamer, 3300 W. North Avenue—16
Dana, Edward R., 4214 Greenway—18
Dandy, Walter Edward, Jr., 3904 Juniper Road—18
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Darby, William A., Medical Arts Bldg.—1
Davidov, Nathan J., 3218 Eastern Avenue—24
Davidson, Charles Nuchols, 5900 Lakehurst Avenue—10
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§Davis, E. Hollister, 3301 N. Charles Street—18
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§Day, Newland E., 4 East 33rd Street—18
Debuskey, Matthew, 2412 Eutaw Place—17
De Carlo, John, Jr., 1211 Cochran Avenue—12
Deckert, W. Allen, 1114 St. Paul Street—2
De Hoff, George W., 2020 N. Charles Street—18
§De Hoff, John Burling, 2020 N. Charles Street—18
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Demarco, Salvatore J., Jr., 715 N. Charles Street—1
§Dennis, John Murray, University Hospital—1
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Devlin, Andrew Joseph, Jr., 1041 Maiden Choice Lane—29
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Drozd, Joseph, 240 S. Ann Street—31
Dudley, Albert Henry, Jr., 1201 N. Calvert Street—2
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§Dugan, Hammond J., Jr., 15 E. Biddle Street—2
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Eaton, W. Drummond, 11 E. Chase Street—2
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Edmonds, Charles William, 2746 Alameda Blvd.—18
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§English, Max R., 5713 Belair Road—6
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Grossman, I. Karl, 1212 N. Patterson Park Avenue—13
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§Gundry, Lewis P., Relay 27, Md.
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Gutman, Isaac, 817 St. Paul Street —2

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Hahn, Richard D., 1823 Park Avenue—17
Haines, John S., 11 E. Chase Street —2
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*Hall, Elmer Gill, 1631 E. North Avenue—13
Hall, William S., 215 Woodlawn Road—10
Hamburger, Louis P., 1207 Eutaw Place—17
Hamburger, Louis P., Jr., 1207 Eutaw Place—17
*Hammer, Howell I., 1929 Edmondson Avenue—23
Hanchett, Richard B., Medical Arts Bldg.—1
Handelsman, Jacob Charles, 1112 N. Charles Street—2
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Hanson, Arthur M., Stockton State Hospital, Stockton, Calif.
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Hardy, Janet B., Glenarm, Md.
Harmon, Louis E., 2224 Madison Avenue—17
Harper, Paul, 615 N. Wolfe Street —5
Harris, S. Elliott, 8100 Harford Road—14
Harris, Thomas W., 1824 W. Franklin Street—23
Harrison, Clinton Rabbe, 6 E. Eager Street—2
Harrison, Edmund P. H., 2903 N. Charles Street—18
Harrison, Harold E., 3001 Fordney Lane—7
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Hartman, Oscar, 1801 Eutaw Place —17
Hartmann, William L., Multnomah County Med. Society, Multnomah, Ore.
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§Harvey, A. McGehee, Johns Hopkins Hospital—5
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§Haws, John March, 1201 N. Calvert Street—2
§Hayleck, Mary L., 4401 Underwood Road—18
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Healy, Robert F., Medical Arts Bldg.—1
Hebb, Donald B., Cockeysville, Md.
Hecker, Erwin, 3668 Forest Garden Avenue—7
Heghinian, Jeannette R., 2212 South Road—9
Heinbach, Anne Booth, St. Joseph's Hospital—13
Heinbach, Wilfred F., St. Joseph's Hospital—13
§Heldrich, Frederick Joseph, Jr., 1047 Cooks Lane—29
Helfrich, Raymond F., 519 Lyndhurst Street—29
§Helfrich, William G., 5006 Roland Avenue—10
Henning, Emil Heller, Jr., 601 Winans Way—29
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Herbert, Thomas Franklyn, 46 Church Road, Ellicott City, Md.
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Herold, Paul Garmer, 1222 Walters Avenue—12
§Hersperger, W. Grafton, 12 E. 33rd Street—18
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Hobelman, Charles F., 21 W. 27th. Street—18
Hoffman, Elmer, 3501 St. Paul Street—18
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Hooper, Z. Vance, 3534 Ellerslie Avenue—18
Hope, Daniel, Jr., Braewood-S. Rolling Rd.—28
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§Hopkins, James E. T., 104 W. Madison Street—1
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Hulla, Jaroslav, 2214 E. Fayette Street—31
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§Kardash, Theodore, Medical Arts Bldg.—1
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Leitz, T. Frederick, Temple Garden Apartments—17
Lenhard, Raymond E., 1107 St. Paul Street—2
§Lerner, Philip F., 1111 St. Paul Street—2
§Leslie, Franklin Earl, 623 Wilton Road, Towson—4
Levi, J. Elliot, 1020 St. Paul Street —2
Levickas, Herbert J., 5305 East Drive—27
Levin, H. Edmund, 3400 Hilton Road—15
Levin, Manuel, 4818 Reisterstown Road—15
§Levin, Milton, 2240 Eutaw Place —17
Levin, Morris Benjamin, 218 E. University Parkway—18
Levin, Norman, 3412 Cedardale Road—15
Levine, Stuart C., 809 Cathedral Street—1
§Levy, Charles S., Medical Arts Bldg.—1
Levy, Isidore I., 3530 Hilton Road —15
§Levy, Kurt, 3103 N. Charles Street —18
Levy, Walter Howard, 3704 Winterbourne Road—16
Lewis, J. L., Jr., 5907 Wakehurst Way—12
§Lewison, Edward F., 1020 St. Paul Street—2
Liang, Ping Y., 700 Cathedral Street—1
Liberles, Lucille, 1739 Eutaw Place —17
Liberto, Joseph Robert, 1011 N. Charles Street—1
Lichtenstein, Gemma Margaret, 616 Walker Avenue—12
Lieberman, Alfred T., 29 E. Mt. Vernon Place—2
Lilienfeld, Samuel, 714 East Preston Street—2
Lilienthal, Joseph L., Jr., Johns Hopkins Hospital—5
Linas, Sidney, 2240 Eutaw Place—17
Linden, Harry, 14 S. Broadway—31
Li Pira, Joseph Francis, 8400 Loch Raven Blvd.—4
Lippy, George D., 206 Kimble Road—18
Lisansky, Ephraim T., 3210 Liberty Heights Avenue—15

* Deceased.
§ Wife is a member of the Woman's Auxiliary to the Medical and Chirurgical Faculty.

Liteanu, Michael, 3701 Clarks Lane—15
Little, Luther E., 10 W. Madison Street—1
Livingston, Samuel, 1039 St. Paul Street—2
§Lloyd, Oliver S., 701 Cathedral Street—1
Loch, Walter E., 1039 North Calvert Street—2
Lockard, James Douglas, 802 Cathedral Street—1
Loewald, Hans W., 11 E. Chase Street—2
Loker, F. Ford, 1120 St. Paul Street—2
§Long, John Herman, 11 E. Chase Street—2
Long, Wilmer Newton, Jr., 3332 St. Paul Street—18
Love, William S., 1214 N. Calvert Street—2
Lovitt, William V., Jr., 3501 St. Paul Street, Apt. 532—18
Lowitz, Irving Robert, 6021 Highgate Drive—15
Lowman, Milton E., 4843 Park Heights Avenue—15
Lukens, David, Johns Hopkins Hospital—5
*Luetscher, John A., 12 East Eager Street—2
Lumpkin, Morgan Leroy, 914 N. Charles Street—1
§Lumpkin, Wm. Randolph, 618 Valley Lane, Towson—4
§Lyden, Robert James, 5818 Edge Park Road—14
§Lupo, Deonis M., 11 E. Chase Street—2
§Lynn, William Dawson, 1547 Northgate Road—18
McCarthy, Charlotte, 2919 St. Paul Street—18
McCarty, Harry D., 37 W. Preston Street—1
McCauley, A. Franklin, 2843 St. Paul Street—18
§McClafferty, William J., 315 St. Dunstans Road—12
McClary, Allan R., 411 Alabama Road, Towson—4
McCormack, Lloyd L., 901 St. Paul Street—2
McCosh, James N., 312 Dixie Drive—4
McDonald, George, 844 N. Carey Street—17
McDonnell, Edmond J., 4 E. Madison Street—2
McElwain, Howard B., 31 E. North Avenue—2
McFadden, Robert B., 19 Wyndcrest Avenue—28
McGrady, Charles Winfred, Jr., University Hospital—1
McGrady, Kathleen Reilly, University Hospital—1
McGrath, Dennis Joseph, 1 East Randall Street—30
§McKay, John Nelson, 6014 Edmondson Avenue—28
McKenzie, W. Raymond, Medical Arts Bldg.—1
McKewen, Jane B., 406 Alleghany Ave., Towson—4
McKusick, Victor A., Johns Hopkins Hospital—5
§McLanahan, Samuel, 108 E. 33rd Street—18
McLaughlin, Francis Joseph, 2 E. Read Street—2
McLaughlin, John H., 3700 Loch Raven Blvd.—18
McLean, George, Medical Arts Bldg.—1
McLean, Ross L., 3900 Loch Raven Blvd.—18
McNally, Hugh B., 1008 Winding Way—10
Mace, Albert J., The Terrace, Mt. Washington—9
Machen, John W., 6331 Belair Road—6
Macht, Allan Harris, 3818½ Belle Avenue—15
Macht, David I., 3420 Auchentoroly Terrace—17
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Macks, Isaac. M, 3506 Liberty Heights Avenue—15
MacLaughlin, D. C., 4508 Edmondson Village—29
§MacLean, Angus L., 1201 N. Calvert Street—2
MacMinn, Charles C., Jr., 2911 E. Baltimore Street—24
Maginnis, Helen Irene, 5003 Edmondson Avenue—29
Magladery, John William, Johns Hopkins Hospital—5
§Magruder, William Wailes, 1686 Waverly Way—12
Mandy, Arthur Jennings, Medical Arts Bldg.—1
Mandy, Theodore E., Medical Arts Bldg.—1
Manieri, Frank V., 3503 Crossland Avenue—13
Mansdorfer, G. Bowers, 2937 N. Charles Street—18
§Mansfield, W. Kenneth, 44 West Biddle Street—1
Marburg, Rudolf, 2 E. Read Street—2
Marek, Charles B., Medical Arts Bldg.—1
Marino, Frank C., 1129 St. Paul Street—2
Mark, Donald D., 3234 Lake Avenue—13
§Markley, Raymond Law, Medical Arts Bldg.—1
Markowitz, Milton, 1109 St. Paul Street—2
Marr, Ernest G., 516 Cathedral Street—1
Marr, William G., 10 E. Chase Street—2
Marriott, Henry J. L., 5003 Wetheredsville Road—7
Marshall, Curtis, Johns Hopkins Hospital—5
Marston, James G., 516 Cathedral Street—1
Martin, Lay, 1201 N. Calvert Street—2
Maser, Louis R., 4335 Park Heights Avenue—15
Maseritz, I. H., Temple Garden Apts., Cloverdale Road & Madison Avenue—17
Mason, Robert E., 9 E. Chase Street—2
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Maxson, Charles Walter, 817 St. Paul St., Apt. 609—2
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§ Wife is a member of the Woman's Auxiliary to the Medical and Chirurgical Faculty.

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Mayer, Erwin E., The Esplanade—17
§Mays, Howard B., 715 N. Charles Street—1
§Mech, Karl F., 11 E. Chase Street—2
Menning, Joseph H., 101 W. Read Street—1
Meranski, Israel P., 3354 Dolfield Avenue—15
Merkel, Walter C., Union Memorial Hospital—18
Meyer, Eugene, III, 809 W. Lake Avenue—10
Michel, William, 1015 Poplar Grove Street—16
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Michelson, Elliott, 1801 Eutaw Place—17
Milan, Albert Richard, 320 E. 33rd Street—18
Milan, Edward Fortune, 682 Washington Blvd.—30
Millea, William L., 3101 St. Paul Street—18
Miller, Benjamin, 2030 Wilkens Avenue—23
Miller, Harry A., 2452 Eutaw Place—17
Miller, Isaac, 1228 S. Charles Street—30
Miller, Jacob M., 1613 E. Baltimore Street—31
Miller, James Patton, 804 Cathedral Street—1
§Miller, John Ernest, 719 Morningside Drive, Towson—4
Miller, Joseph G., 107 W. Saratoga Street—1
Miller, Mitchell H., 600 W. Belvedere Avenue—10
Miller, Stanley, 914 N. Charles Street—1
Milnor, William R., Malvern Avenue, Ruxton—4
Mintzer, Donald W., 1922 E. Belvedere Avenue—14
Mirick, George S., Baltimore City Hospitals—24
Mitchell, G. W., 11 E. Chase Street—2
§Mitchell, John A., 422 Medical Arts Bldg.—1
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Monninger, Arthur C., 800 E. North Avenue—2
Moore, Alfred C., 2122 Broening Highway—24
Moore, James I., 11 E. Chase Street—2
Moore, Jos. Earle, Medical Arts Bldg.—1
Moore, Kirk, The Latrobe Apts.—2
Moore, Marcus W., Sr., 1371 N. Carey Street—17
Moores, J. Duer, 3105 Belair Road—13
Morgan, Russell H., Johns Hopkins Hospital—5
§Morgan, Zachariah R., 10 E. Eager Street—2
Morris, Frank K., 3913 Juniper Road—18
Morris, John D., 2 W. University Parkway—18
§Morrison, John Huff, 6 E. Read Street—2
Morrison, Samuel, 11 E. Chase Street—2
§Morrison, Theodore H., 11 E. Chase Street—2
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Murphy, Bernard William, Forsythe Road, Sykesville, Md.
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Muse, Joseph E., Jr., 5 West 29th Street—18
Muse, William T., 2436 Washington Blvd.—30
Myerowitz, Joseph R., 5145 Park Heights Avenue—15
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§Myers, Joseph Carl, 1401 E. Coldspring Lane—12
Myers, Myron Joseph, The Latrobe Apartments—2
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Nance, Fuller, Seton Institute, 6420 Reisterstown Road—15
§Needle, Nathan E., 4215 Park Heights Avenue—15
Neill, William, Jr., 3917 Canterbury Road—18
Nelson, Alfred S., 103 Stevenson Lane—12
§Nelson, Alfred T., 4526 Marble Hall Road—12
Nelson, James Wharton, Stevenson Lane and Club Road—4
Nesbitt, John A., Jr., 1118 St. Paul Street—2
Neubauer, Imre, 936 Patapsco Avenue—25
Neustadt, John O., 1926 McElderry Street—5
Ney, Grover C., 2401 Linden Avenue—17
Niblett, Walter S., 2220 Garrison Avenue—16
Nichols, Firmadge King, 4711 Roland Avenue—10
§Niermann, William Albert, 3101 St. Paul Street—18
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Norton, Austin T., 1627 Freedomway North—13
Norton, John Charles, 1933 W. Baltimore Street—23
Norwood, Vernon H., Church Home & Hospital—31

§ Wife is a member of the Woman's Auxiliary to the Medical and Chirurgical Faculty.

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Novak, Eduard, Medical Arts Bldg. —1
Novak, Emil, 26 E. Preston Street —2
Novey, Riva, 3501 St. Paul Street —18
Nowak, Sigmund R., 408 S. Patterson Park Avenue—31
Noya, Joseph John, 604 N. Chapelgate Lane—29
§O'Connor, John A., 11 E. Chase Street—2
O'Dell, John Clayton, 3706 N. Charles Street—18
O'Donovan, Charles, Jr., 3111 N. Charles Street—18
Ogden, Frank N., 2701 N. Calvert Street—18
O'Hare, James Stewart, 6 E. 30th. Street—18
§O'Rourk, Thomas R., 104 W. Madison Street—1
Osborne, John C., 3122 Northern Parkway—14
§Ossman, Alfred G., Jr., 3219 N. Calvert Street—18
Otenasek, Frank J., 6 East Eager Street—2
Owen, Arthur J., 1200 E. Belvedere Avenue—13
§Owen, John Keller, 104 W. Madison Street—1
§Owings, James C., 18 W. Franklin Street—1
§Ozazewski, John Casimir, 1540 Oakridge Road—18
Pacienza, Frank Anthony, Medical Arts Bldg.—1
§Padussis, Stephen K., 3301 N. Charles Street—18
Pair, James Mansfield, 400 N. Carrollton Avenue—23
Palese, John M., 2412 Pelham Avenue—13
Palmisano, Joseph Frank, 6014 Loch Raven Blvd.—12
Parelhoff, Merrill E., 903 Lake Drive—17
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Patton, Genieann Parker, 7727 York Road—4
Patz, Arnall, 920 St. Paul Street—2
§Paulson, Moses, 11 E. Chase Street—2
Peake, Clarence W., 4508 Harford Road—14
Pearce, William F., 2105 N. Charles Street—18
Peck, John L., 5506 Lombardy Place—10
Pembroke, Richard H., Jr., 1311 N. Calvert Street—2
Pendleton, George H., 1723 Druid Hill Avenue—17
Perilla, F. Robert, 3601 Hicks Avenue—7
Perlman, Anthony, 1109 St. Paul Street—2
§Pessagno, Daniel J., Medical Arts Bldg.—1
Peters, H. Raymond, 1127 N. Calvert Street—2
Phelan, Patrick C., Jr., 255 Linden Avenue, Towson—4
Phelps, Winthrop Morgan, 3038 St. Paul Street—18
Phillips, Otto C., 2225 Lake Avenue —13
§Pierce, Leslie Harrall, 700 Cathedral Street—1
§Pierpont, Ross Z., 111 W. Monument Street—1
Pierson, J. W., 1107 St. Paul Street—2
§Pincoffs, Maurice C., University Hospital—1
Pines, Samuel R., The Latrobe Apartments—2
Pinkney, Talmadge Hall, 2310 W. North Avenue—16
Pleasants, Jacob H., 201 Longwood Road—10
Pleet, Jerome, 3717 Sequoia Avenue —15
Polek, Melvin F., 3603 Belair Road —13
Polvogt, Leroy M., 1201 N. Calvert Street—2
Porter, Harry P., 6473 Blenheim Road—12
Post, William R., 2120 Main Street, Springfield, Ore.
Prager, Helmut, 1308 Eutaw Place —17
Prather, Perry F., 5203 Falls Road, Apt. 7—10
Primakoff, H. William, Emersonian Apartments—17
Proctor, Donald F., Johns Hopkins Hospital—5
§Proctor, Samuel E., 104 W. Madison Street—1
Queen, J. Emmett, 4418 Norwood Road—18
Racusin, Nathan, 206 S. Gilmore Street—23
§Radman, H. Melvin, Esplanade Apts., Eutaw Place & Brooks Lane—17
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Ramirez, Rafael V., 523 N. Denison Street—29
Ramsey, James H., Dept. of Pathology, University of Maryland Medical School—1
Ramundo, Michael R., 89 Avondale Avenue, Clifton, N. J.
Randolph, M. Elliott, 11 E. Chase Street—2
§Rangle, Ramond V., 642 Washington Boulevard—30
Raskin, Moses, 817 St. Paul Street —2
Rathbun, Howard K., Carroll Manor Road, Baldwin, Md.
Ratliff, Cliff, Jr., 4605 Edmondson Avenue—29
Reckling, Ralph Weeden, 520 N. Fulton Avenue—17
Reese, Fred M., 330 N. Charles Street—1
Reichelderfer, Thomas E., E-2 Alder Drive—20
§Reifschneider, Charles, 104 W. Madison Street—1
Reifschneider, Herbert E., 104 W. Madison Street—1
§Reiter, Robert A., 3408 Windsor Avenue—16
Renner, William F., 11 West 29th Street—18
§Revell, Samuel T. R., Jr., University Hospital—1
Rever, William Benjamin, Jr., 8100 Kirkwall Court, Towson—4
Rich, Benjamin S., Medical Arts Bldg.—1

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Richardson, Edward H., Jr., 9 E. Chase Street—2
Richardson, Horace K., 11 E. Chase Street—2
Richter, Christian F., 11 W. Biddle Street—1
§Richter, Conrad Louis, 2237 Lake Avenue—13
Ridgely, Irwin O., 201 W. Madison Street—1
Rienhoff, William Francis, Jr., 1201 N. Calvert Street—2
Riley, Eugene John, 209 Cedarcroft Road—12
Riley, Richard Lord, 1901 Dixon Road—9
§Riley, Robert Annan, Jr., 1401 Park Avenue—17
§Rinehart, Arthur Middleton, 4823 Keswick Road—10
Rinn, William Alexander, Medical Arts Bldg.—1
Rizika, Stuart D., 3411 Rosedale Road—15
Roach, Thomas Edward, 514 Drury Lane—29
Robbins, Martin A., 1801 Eutaw Place—17
Roberts, David P., 11 E. Chase Street—2
Robertson, J. Clagett, Sr., 117 S. Broadway—31
Robinson, Aaron, 1817 Eutaw Place —17
Robinson, Harry M., 106 E. Chase Street—2
§Robinson, Harry M., Jr., 1024 N. Calvert Street—2
Robinson, Kent Edward, Dept. of Psychiatry, University of Maryland School of Medicine—1
Robinson, Raymond C. V., 11 Murray Hill Circle—12
Robinson, Robert Alexander, 314 Broxton Road—12
Robnett,* Dudley Anderson, Jr., P.O. Box 2415, % Mrs. W. D. Powell, Carmel, Cal.
§Rochberg, Samuel, 2202 W. Rogers Avenue—15
Rodgers, William A., 815 Eastern Avenue—21
Roetling, Carl P., 1326 W. Lombard Street—25
Rogers, Harry L., 101 E. Preston Street—2
Roman, Paul W., 1810 Eutaw Place —17
Rombro, Marvin Jay, 3824 W. Cold Spring Lane—15
§Rosen, Harold, 1101 N. Calvert Street—2
Rosen, Israel, 2413 E. Monument Street—5
Rosenfeld, Morris, 3921 Pinkney Road—15
Rosenthal, Gilbert W., 1739 Eutaw Place—17
Rosenthal, Harry William, 432 E. North Avenue—2
Rosin, John David, 1010 St. Paul Street—2
Ross, Richard S., 1938 McElderry Street—5
Rossberg, Clyde Arthur, 2436 Washington Boulevard—30
Rothholz, Alma S., 822 Belgian Avenue., Apt. 1-C—18
*Rowland, James M. H., 1118 St. Paul Street—2
Rowland, William Marshall, 5502 Huntley Square—10
Rubin, Samuel, 1109 N. Calvert Street—2
Rubin, Samuel, 203 Patapsco Avenue —25
Rubin, Seymour H., 1331 E. North Avenue—13
Rubinstein, Hyman S., 2349 Eutaw Place—17
Rudin, Louis N., 5901 Ayleshire Road—12
Rudman, Gilbert E., 2517 W. Baltimore Street—23
§Rudo, Alvin D., The Latrobe Apartments—2
Russell, Thomas Edgie, Jr., 3901 N. Charles Street—18
§Russo, James, 02027963, 3440th USAH, Ft. Benning, Ga.
Rutledge, Benjamin H., 18 E. Eager Street—2
Ruzicka, F. Fred, 800 N. Patterson Park Avenue—5
Rysanek, William J., Sr., 801 N. Kenwood Avenue—5
Rysanek, William James, Jr., 1013 N. Calvert Street—2
§Sachs, Louis, Marlborough Apts.—17
Sacks, Milton S., University Hospital—1
Safar, Peter, Johns Hopkins Hospital—5
Salik, Julian O., 3602 Clarinth Road —15
Sanderson, J. W., 1714 N. Caroline Street—13
Sanford, Marshall Clement, 11 E. Chase Street—2
Sardo, Robert S., 303 Woodbourne Avenue—12
Sarubin, Benjamin, 2031 Eutaw Place—17
Sauber, Irvin, 3003 Garrison Boulevard—16
§Saunders, Leroy W., 216 Goodale Road—12
§Savage, John Edward, 811 Boyce Avenue—4
Sawyer, George J., Jr., 4808 Harford Road—14
Sawyer, William H., Jr., 4928 West Hills Road—29
Saylor, Lloyd E., 3902 Greenmount Avenue—18
§Sborofsky, Isadore, 4212 Oakford Avenue—15
§Scagnetti, Albert, 1729 W. Lombard Street—23
§Scarborough, Clarence P., Jr., 104 W. Madison Street—1
Schaefer, John F., 401 Random Road—29
Schaefer, Otto, 920 St. Paul Street —2
Schaffer, Alexander J., 1109 St. Paul Street—2
Schapiro, Abraham, 2028 Eutaw Place—17
Schapiro, William B., 2415 Eutaw Place—17
Schenker, Paul, 2424 Eutaw Place —17
Scher, Ernest, 1701 Eutaw Place—17
Scher, Isadore, 2502 Eutaw Place —17
Scherlis, Irving, 3501 Overbrook Road—8
§Scherlis, Leonard, 1214 N. Calvert Street—2
Scherlis, Sidney, 1214 N. Calvert Street—2
Scheurich, John A., 1337 S. Charles Street—30

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§ Wife is a member of the Woman's Auxiliary to the Medical and Chirurgical Faculty.

Scheye, Henry W., 3921 Edmondson Avenue—29
Schiff, Hyman, 4023 Fallstaff Road —15
§Schimunek, Emmanuel, 842 S. East Avenue—24
Schlesinger, George G., 16 E. Biddle Street—2
Schmitz, William J., 118 Midhurst Road—12
Schnaper, Nathan, 1214 N. Calvert Street—2
Schneidmuhl, Abraham M., 3340 Dolfield Avenue—15
Schnitzer, D. Eugene, 3904 S. Hanover Street—25
Schochet, George, 6111 Baywood Avenue—9
Schoenrich, Edyth Hull, 1682 Waverly Way—12
§Schoenrich, Herbert, Preston and Calvert Streets—2
Scholz, Roy O., 11 Blythewood Road—10
Schonfeld, Paul, 2301 Annapolis Road—30
Schreiber, M. B., 3506 Ellamont Road—15
Schultz, Kathryn L., 2 E. Read Street—2
Schuman, William, 1716 Eutaw Place—17
Schwartz, Daniel J., 2320 Eutaw Place—17
§Schwartz, Theodore A., 834 Park Avenue—1
*Schwentker, Francis F., 209 Tunbridge Road—12
Scott, Eleanor, 1014 St. Paul Street—2
Scott, Harry Baty, 1306 Wildwood Parkway—29
§Scott, John M., 8 Longwood Road—10
Scott, William W., Rider Hill Road, Ruxton—4
Seaton, Ronald Stuart, Church Home & Hospital—31
Seegar, J. King B. E., Jr., 3714 Winterbourne Road—16
§Seidel, Henry Murray, 3825 Labyrinth Road—15
Seidel, Herman, 2404 Eutaw Place—17
Selenkow, Herbert A., Johns Hopkins Hospital—5
Seligman, Arnold M., Sinai Hospital —5
Serra, Lawrence M., 11 E. Chase Street—2
§Settle, William B., 126 Homeland Avenue—12
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Shackman, Albert B., Medical Arts Bldg.—1
Shamer, Maurice E., 3300 W. North Avenue—16
§Shanahan, Daniel S., 1945 W. Baltimore Street—23
Shannon, George E., Medical Arts Bldg.—1
§Shapiro, Albert, 1109 N. Calvert Street—2
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Sheppard, Robert C., Medical Arts Bldg.—1
Shepperd, J. Douglass, 604 N. Fulton Avenue—17
Sherman, Harry Donald, 2326 Eutaw Place—17
Sherman, Jerome, 2502 Eutaw Place—17
Sherman, Solomon, 2424 Eutaw Place—17
Sherry, Milton, 11 E. Chase Street —2
Shervington, E. Walter, 2301 Harlem Avenue—16
Shiling, Moses S., 2426 Eutaw Place—17
Shimanek, Lawrence Joseph, 803 South Wind Court—4
Shipley, Arthur M., 507 Edgevale Road—10
§Shipley, E. Roderick, Medical Arts Bldg.—1
Shochat, Albert J., 4111 Liberty Heights Avenue—7
*Shpritz, Nathan H., 3100 Garrison Boulevard—16
Shulman, Alfred J., The Latrobe Apartments—2
§Shulman, Leon M., 6715 Park Heights Avenue—15
Siegel, Isadore A., 6400 Park Heights Avenue—15
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Sima, Charles E., 2074 E. Belvedere Avenue—14
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Sindler, Richard Arnold, 714 N. Broadway—5
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Singewald, Martin L., 11 E. Chase Street—2
Singleton, Robert Tiffany, 903 N. Woodington Road—29
Sinn, Charles M., 606 Walker Avenue—12
Sisco, Patience S. Bourdeau, 2500 Garrison Blvd.—16
Siscovick, Milton, 1429 W. Fayette Street—23
Siver, Robert H., 3105 N. Charles Street—18
Siwinski, Arthur G., 15 E. Biddle Street—2
Siwinski, Thaddeus C., 17 W. Pennsylvania Avenue—4
Skloven, Joseph, 7122 Harford Road—14
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Slager, Ursula Traugott, 730 Ashburton Street—16
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Smink, Claud, St. Michaels, Md.
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Smith, E. P., 920 St. Paul Street—2
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Smith, George William, Johns Hopkins Hospital—5
Smith, Harry B., 7201 Oxford Road—12
§Smith, Howard Chandler, Medical Arts Bldg.—1
§Smith, John P., 1100 East Belvedere Avenue, Apt. A—12
Smith, Olive Cushing, 20 W. Madison Street—1
Smith, Ruby A., 513 N. Charles Street—1
Smith, Sol, 2426 Eutaw Place—17
Smith, Wm. H., 3429 Chestnut Avenue—11
Smith, Winford, 100 W. University Parkway—10
Snyder, Jerome, 11 E. Chase Street—2
Snyder, Nathan, 1200 St. Paul Street—2
Snyder, Samuel, 1634 E. Baltimore Street—31
Sodaro, Manuel, 826 E. Belvedere Avenue—12
§Sollod, Aaron C., 707 E. Fort Avenue —30
Solomon, Milton L., 129 S. Broadway—31
Solowiej, Wladimir, 2811 Eastern Avenue—24
Sondheimer, A. Adler, Esplanade Apts.—17
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Speed, William George, III, 11 E. Chase Street—2
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Gerwig, Walter H., Jr., 1805 Kenyon Street, N. W., Washington, D. C.
Godlove, John Carlton, 409 W. King Street, Martinsburg, W. Va.
Graham, Robert Lee, Winter V.A. Hospital, Topeka, Kansas
*Grant, Harry C., Sr., Veterans Administration Regional Office, 2320 La Branch Street, Houston, Texas
Greenberg, Alfred, 14529½ Clark Street, Van Nuys, Calif.
Grief, Roger L., Hospital of The Rockefeller Institute for Medical Research, 66th Street & York Avenue, New York 21, New York
Hauber, Frank D., 3200 Vine Street, V.A. Hospital, Cincinnati, Ohio
*Hazard, Elmer C., 75 Washington Street, Long Branch, N. J.
Kaufman, Helene Brickman, 6 Platt Street, Poughkeepsie, N. Y.
Keeney, Edmund L., 1540 Sixth Avenue, San Diego 1, Cal.
Kemick, Irvin B., 3395 Scranton Street, City Hospital, Cleveland 9, Ohio
Ketzky, Joseph William, 4544 Alton Road, Miami Beach 40, Fla.
Lamkin, Edward E., Blackstone Apartments, Charles and Thirty-third Streets, Baltimore 18, Md.
Lipin, Raymond J., V.A. Hospital, 300 E. Roosevelt Road, Little Rock, Ark.
Lyford, John, III, Veterans Administration Hospital, Louisville 2, Ky.
Lyon, William Cochran, 2401 Indian Village Building, Ft. Wayne, Ind.
Miller, Robert T., Mountain Lake, Lake Wales, Florida
Mitchell, Henry S., V.A. Center, Martinsburg, West Va.
Mitchell, William Arthur, 201 Hemenway Building, Lufkin, Texas
Wolofsky, Leonard Carl, Kaiser Foundation Hospital, Broadway & McArthur Boulevard, Oakland 11, Calif.
Owens, Ella Uhler, 7705 – 13th Street, N. W., Washington 12, D. C.
Peirce, E. Converse, II, 4107 Tazwell Pike, Knoxville 18, Tenn.
Pratt, Daniel W., University of Virginia Hospital, Charlottesville, Va.
Ravitch, Mark M., Mt. Sinai Hospital, New York, N. Y.
Robinson, Daniel R., V.A. Hospital, 1481 W. 10th Street, Indianapolis 7, Ind.
Schenthal, Joseph Edwin, 1328 Aline St., New Orleans 15, La.
Scherr, Merle Sundrell, MC, 0400-3889, Fitzsimons Army Hospital, Denver, Colo.
Shelley, Harry S., 3725 Estes Avenue, Nashville, Tenn.
Shub, Maurice I., 559 Hillside Avenue, Elmhurst, Ill.
Steinberg, Stanley H., 4214 16th Street, N. W., Washington, D. C.
Thompson, Charles Baker, Lifwynn Foundation, Westport, Connecticut
Virgilio, Frank D., U.S.N. P.F., Indian Head, Md.
Warren, Thomas N., U. S. Quarantine Station, Rosebank, Staten Island 5, N. Y.

* Deceased.
§ Wife is a member of the Woman's Auxiliary to the Medical and Chirurgical Faculty.

Component Medical Societies

ALLEGANY-GARRETT COUNTY MEDICAL SOCIETY

LESLIE E. DAUGHERTY, M.D.

Journal Representative

GOVERNOR McKELDIN ADDRESSES COMMUNITY OF FROSTBURG AT DEDICATION OF MINER'S HOSPITAL MATERNITY WING

Governor Theodore R. McKeldin attended the formal dedication of the new maternity wing completed recently, as an addition to Miner's Hospital, in Frostburg, Maryland. Governor McKeldin in his address congratulated the residents of Frostburg upon their foresight in requesting the new addition.

Twenty-six new beds and five bassinets were added in the new wing, which makes the bed capacity in the Miner's Hospital now seventy-five beds and eighteen bassinets.

Dr. H. C. Diehl is president of the Medical Staff, Dr. F. T. Harrat, vice-president, Dr. Martin M. Rothstein, secretary and Dr. W. O. McLane is a member on the Board of Directors.

PERSONALS

Dr. W. Royce Hodges, of Cumberland, Maryland addressed the Methodist Youth Conference, held recently at the Centre St. Methodist Church, in Cumberland. His topic was "Choosing a Career in Christian Related Vocations."

Dr. John B. Davis, Frostburg physician, was injured June 7 when his car skidded on the wet highway between Cumberland and Frostburg. He remains in the Miner's Hospital, in Frostburg, in fair condition.

Dr. W. F. Williams, representing the medical and surgical staff of Memorial Hospital, Cumberland, Maryland presented the nurse's awards at the annual commencement exercises, held in June, at the Fort Hill High School auditorium, Cumberland.

Dr. and Mrs. Anderson J. Fazenbaker, Westernport, Maryland were honored at a party recently, on their twenty-fifth wedding anniversary. Dr. Fazenbaker has been practicing in Westernport since 1921.

Members attending the American Medical Association annual meeting in Atlantic City, in June, from Allegany-Garrett County Medical Society were; Doctors, H. C. Diehl, F. T. Harrat and M. M. Rothstein, from Frostburg; Drs. Royce W. Hodges, Leslie E. Daugherty, R. W. Trevaskis, Sr. and Frank A. Cawley, of Cumberland, and Dr. E. I. Baumgartner, of Oakland. Dr. Baumgartner was secretary of the Section on General Practice.

FREDERICK COUNTY MEDICAL SOCIETY

LOUIS R. SCHOOLMAN, M.D.

Journal Representative

The regular May meeting was held at Schley Inn May 17th. The speaker of the evening was Dr. Florence Mahoney, Director of the Department of Physical Medicine in the Chronic Hospitals of Maryland. Dr. Mahoney outlined the psychologic approach and demonstrated the techniques found successful in rehabilitating hemiplegics. The talk stimulated considerable discussion and evoked an invitation to Dr. Mahoney to survey our local needs and resources with a view toward the establishment of a rehabilitation center in Frederick. She freely agreed to do this.

The usual appetizing family style dinner was served by the Fischers, proprietors of the Inn. The meal was made memorable by a dessert of the most delicious apple strudel made in Maryland.

HOSPITAL EVENTS

Graduation exercises were held on the evening of May 17th. The speaker, Dr. Mary Frear Keeler, Dean of Faculty at Hood College, likened the discipline of nursing to the polishing of a piece of glass into a bright reflecting mirror. Seven nurses received their diplomas in a pleasant homey ceremony with music.

The Department of Medicine met May 27th. After some discussion it was decided to present a creative plan for a department of rehabilitation to the administration. Dr. Furie then gave a lecture on the coronary circulation.

At the May Clinical Pathologic Conference a case of hemochromatosis complicated by diffuse tuberculosis was presented. A keen young internist who had trained at Boston identified the hemochromatosis without hesitation. A general discussion of the disease then followed.

Health Departments

STATE OF MARYLAND DEPARTMENT OF HEALTH

MONTHLY COMMUNICABLE DISEASE REPORT

Case Reports Received during 4-week Period, July 1–28, 1955

	CHICKENPOX	DIPHTHERIA	GERMAN MEASLES	HEPATITIS, INFECT.	MEASLES	MENINGITIS, MENINGOCOCCUS	MUMPS	POLIOMYELITIS, PARALYTIC	POLIOMYELITIS, NON-PARALYTIC	ROCKY MT. SPOTTED FEVER	STREP. SORE THROAT INCL. SCARLET FEVER	TYPHOID FEVER	UNDULANT FEVER	WHOOPING COUGH	TUBERCULOSIS, RESPIRATORY	SYPHILIS, PRIMARY AND SECONDARY	GONORRHEA	OTHER DISEASES	DEATHS: Influenza and pneumonia
Total, 4 weeks																			
Local areas																			
Baltimore County	11	—	7	3	3	—	9	2	5	1	3	1	—	—	17	—	2	—	6
Anne Arundel	1	—	—	2	2	1	8	2	1	—	—	—	—	—	9	—	2	—	2
Howard	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	1	1	—	—
Harford	1	—	—	—	—	—	1	—	—	—	—	—	—	1	2	—	—	—	1
Carroll	—	—	—	—	1	—	1	—	1	1	—	2	—	—	1	—	—	—	3
Frederick	—	—	—	5	34	—	4	1	—	—	1	—	—	—	2	—	2	—	1
Washington	—	—	—	1	6	—	—	—	—	—	—	—	—	—	4	—	2	—	—
Allegany	—	—	—	1	2	—	2	—	—	—	4	—	—	—	5	—	3	—	—
Garrett	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	—	—	—
Montgomery	3	—	2	19	23	—	4	—	—	—	10	—	—	—	6	—	—	—	6
Prince George's	9	—	—	—	12		7	—	1	2	—	—	—	5	7	1	1	m-1	2
Calvert	—	—	—	—	—	—	2	—	—	—	—	—	—	—	—	—	1	—	—
Charles	—	—	—	—	1	—	4	1	—	—	—	—	—	—	1	—	1	—	—
Saint Mary's	1	—	—	1	5	—	—	—	—	—	1	1	—	2	2	—	—	—	—
Cecil	—	—	—	—	—	—	—	1	—	—	—	—	—	1	2	—	1	—	1
Kent	—	—	—	—	1	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Queen Anne's	—	—	—	—	—	—	—	—	—		—	—	—	—	—	—	—	—	—
Caroline	—	—	—	—	—	—	1	1	—	—	—	—	—	—	1	—	—	—	—
Talbot	—	—	—	—	1	—	—	—	—	—	—	—	—	—	—	1	6	t-1	—
Dorchester	1	—	—	—	—	—	1	1	—	1	—	—	—	—	1	—	1	—	—
Wicomico	—	—	—	—	1	—	4	1	—	—	4	—	—	1	4	—	2	—	3
Worcester	—	—	—	—	—	—	—	—	—	—	1	—	—	—	—	—	—	—	1
Somerset	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	1	—	1
Total Counties	27	0	9	32	92	1	48	10	8	5	24	4	0	10	67	3	53*		27
Baltimore City	19	0	16	4	26	1	45	2	3	0	9	0	0	9	97	18	617	p-1	17
State																			
July 1–28, 1955	46	0	25	36	118	2	93	12	11	5	33	4	0	19	164	21	670		44
Same period 1954	75	1	17	40	236	2	123	9	5	4	30	4	1	95	168	17	689		26
5-year median	75	1	25	—	300	2	149	13		11	23	3	3	62	198	19	668		24
Cumulative totals																			
State																			
Year 1955 to date	2053	8	431	258	1433	21	1368	38	16	15	2132	7	0	244	1192	108	4233		398
Same period 1954	2950	8	271	644	11275	24	2626	16	5	17	1252	11	4	521	1296	103	4245		344
5-year median	2998	16	594	—	5145	47	1935	26		20	1099	15	18	370	1520	157	4094		300

m = malaria, contracted outside the U. S. A.
p = psittacosis.
t = tetanus.
* = total included 27 from migrant labor survey.